

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 08001 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 08001	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Powell, Cora Harris</i>		2. DATE AND HOUR OF DEATH <i>8-17-72</i> <i>1500</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1802</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>70 Harbin View Nursing &amp; Conv.</i>			C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-30-06</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Kr.</i>	
13. FATHER'S NAME <i>William Brickle</i>			14. MOTHER'S MAIDEN NAME <i>Lucy ?</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Cross &amp; Johnson &amp; 306 Edmondson Ave.</i>	
18. <i>19901</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Therapeutic Cancer</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Therapeutic Cancer</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>A.S. G. of disease</i>		(C) <i>?</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Renal Failure</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/24</i> 19 <i>72</i> to <i>8/17</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>7/24</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph S. Blum</i>			23B. DATE SIGNED <i>8/18/72</i>		23C. PHYSICIAN'S NAME (Type) <i>JOSEPH S. BLUM</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>8/21/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Wt. Calvary Cem.</i>
24D. LOCATION (City, town, or county) (State) <i>Cedar Hill Md.</i>			25A. DATE REC'D BY HEALTH DEPT. <i>AUG 22 1972</i>		
25B. NAME OF REGISTRAR <i>William S. Blum</i>			25C. FUNERAL DIRECTOR <i>Williams Funeral Home</i>		

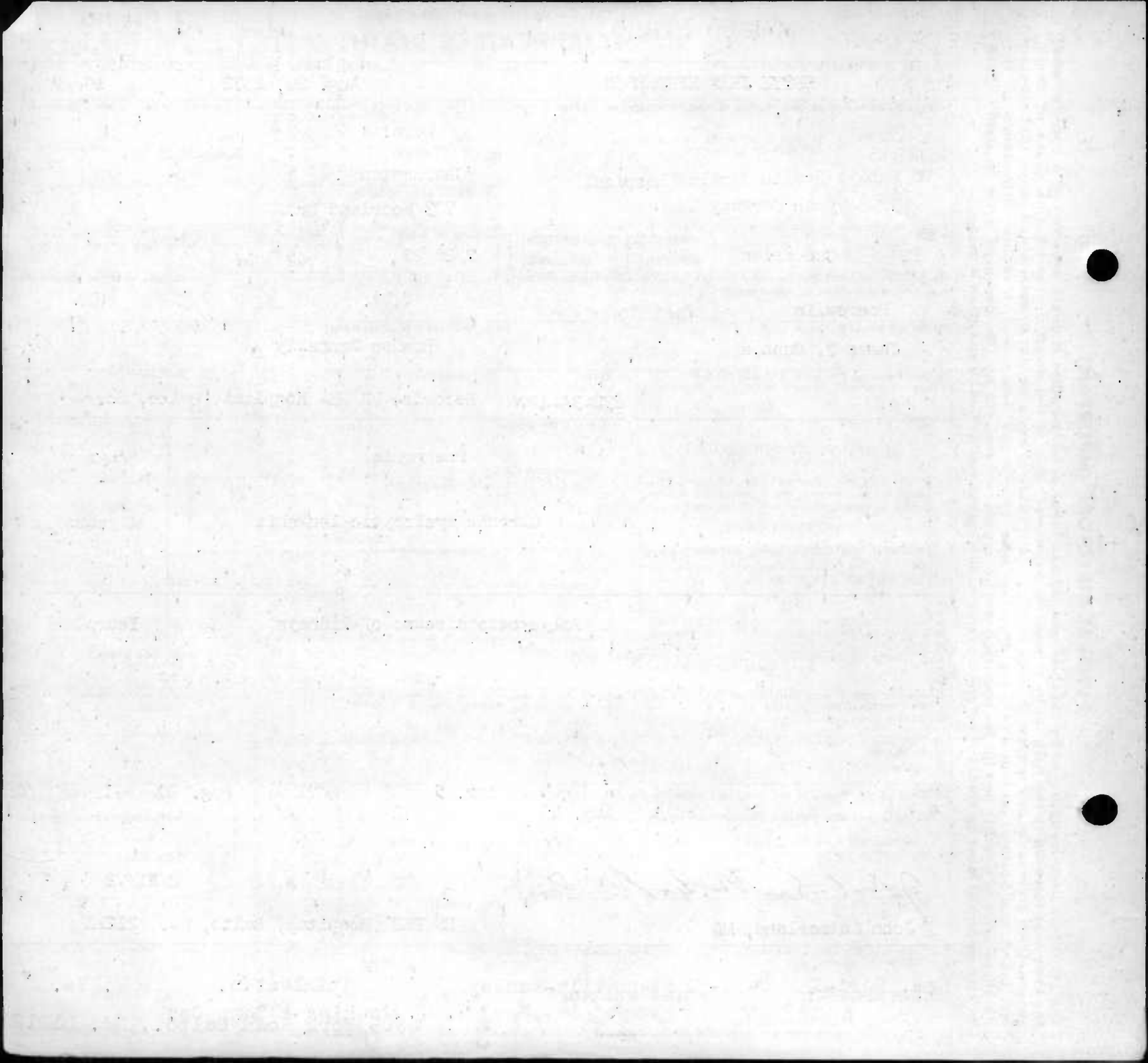
A. 24-100



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08002</u>
72 08002 CERTIFICATE OF DEATH				STATE OF MARYLAND-DMH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BETTY JEAN HENDERSON</b>		2. DATE AND HOUR OF DEATH <b>Aug. 20, 1972</b> <b>10 P M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>W. Va.</b> B. COUNTY <b>V45</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital</b> <b>273100 Wyman Parkway</b>		C. CITY OR TOWN <b>Charleston</b>		D. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
E. STREET AND NUMBER <b>703 Moorland Dr.</b>				
5. SEX <b>F</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/26/27</b>	9. AGE (In years last birthday) <b>45</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>James E. Gunnoe</b>		14. MOTHER'S MAIDEN NAME <b>Louise Donnally</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-34-4976</b>		17. INFORMANT <b>Records- US PHS Hospital, Balto, Md.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic myelocytic leukemia</b>		<b>4 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Polycystic disease of kidneys</b>		<b>Years</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Apr. 5</b> 19 <b>72</b> to <b>Aug. 20</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Aug. 20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>John C. Sutherland, M.D.</i>				23B. DATE SIGNED <b>8/21/72</b>
23C. PHYSICIAN'S NAME (Type) <b>John Sutherland, MD</b>				23D. ADDRESS <b>US PHS Hospital, Balto, Md. 21211</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>8-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Donnally-Nunley</b>
24D. LOCATION (City, town, or county) (State) <b>Charleston, W. Va.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 22 1972</b>		25B. NAME OF REGISTRAR <i>Sydney H. Jenkins</i>		
25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co</b> <b>4905 York Road Balto., Md. 21212</b>				



# FUNERAL DIRECTOR: IMPORTANT

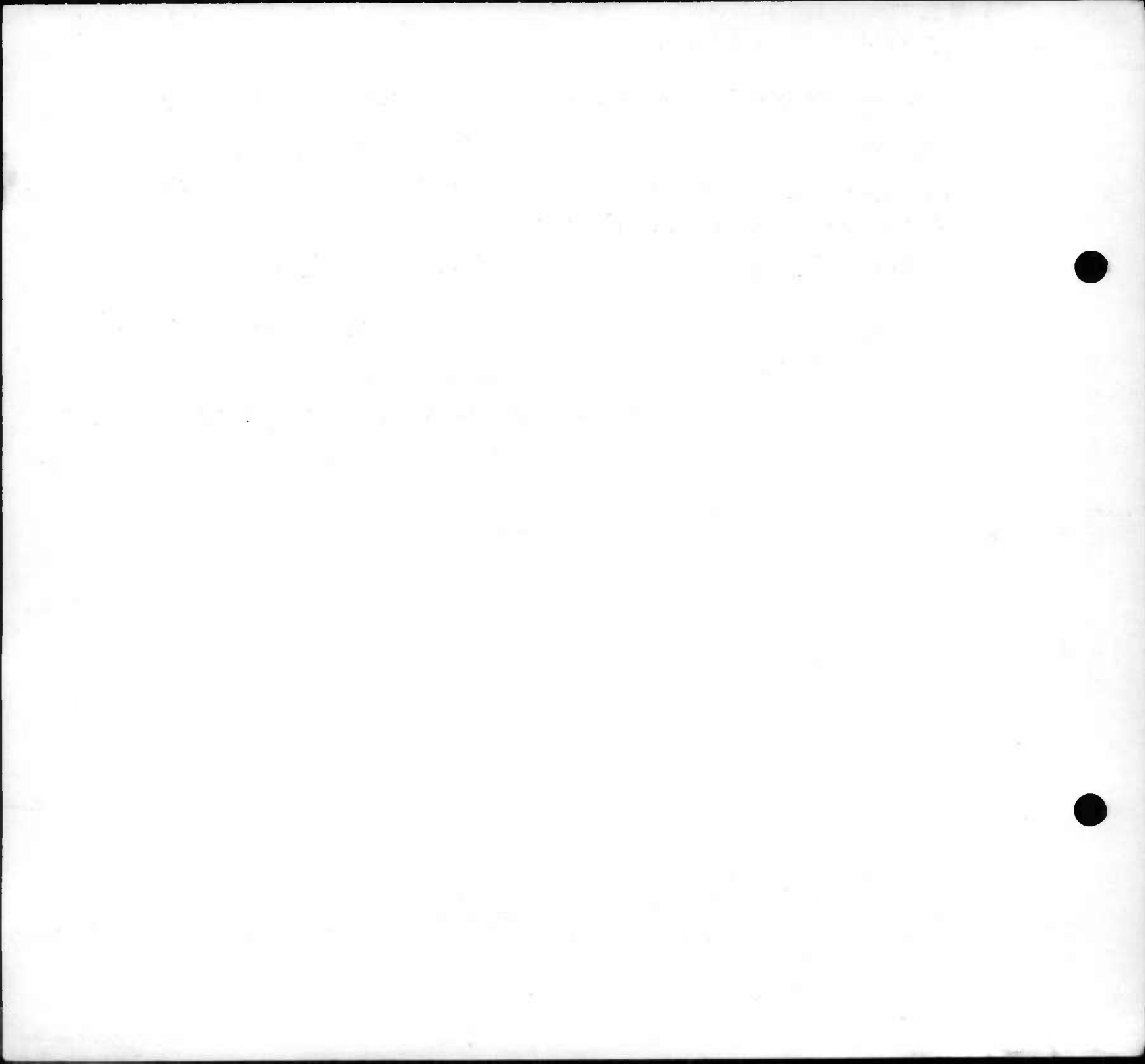
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-622		72 08003		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <span style="border: 1px solid black; padding: 2px;">72 08003</span>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Gorsuch, Edith G.</u>				2. DATE AND HOUR OF DEATH <u>8/18/72</u> <u>1:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Hilton Nsg. Home.</u> <u>3313 Poplar St.</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Glencoe Road</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-25-78</u>	9. AGE (In years last birthday) <u>94</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sparks, Nev.</u> <u>NEVADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles Frederick Germain</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Dorman Gill</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-1706</u>		17. INFORMANT <u>Mrs. Lovelace Slaughter</u>		ADDRESS <u>2918 Glenmore Ave.</u> <u>21214</u>			
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Heart Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Changed arteriosclerosis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Changed arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>8/18/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>7/23/72</u> 19 to <u>8/18/72</u> 19, that (I) (we) last saw the deceased alive on <u>8/18/72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>8/22/72</u>					
23C. PHYSICIAN'S NAME (Type) <u>Thomas Sewardine MD</u>		23D. ADDRESS <u>1501 Greening Rd Baltimore</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-22-72</u>		24C. NAME OF CEMETERY <u>Gorsuch Family Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Glencoe Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Whitton</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Inc.</u>		ADDRESS <u>Towson, Md.</u>			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>4-400</b> <span style="float: right;"><b>72 08004</b></span></p> <p style="text-align: center;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 08004</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>STATE OF MARYLAND - DISTRICT</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>HALL, ALBERT EUGENE</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>DOA 8/17/72 11 AM</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>301</b></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; HOSPITAL</b> <b>BROADWAY &amp; FAYETTE STS. BALTO MD</b></p>		<p><b>C. CITY OR TOWN</b> <b>BALTO. MD</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>5. SEX</b> <b>MALE</b> <b>6. RACE</b> <b>BLACK</b></p>		<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	
<p><b>8. DATE OF BIRTH</b> <b>6/16/24</b> <b>9. AGE (in years last birthday)</b> <b>48</b></p>		<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>	
<p><b>11. BIRTHPLACE</b> (State, or foreign country) <b>Baltimore md</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>		<p><b>13. FATHER'S NAME</b> <b>Sgt Hall</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Helen Allen</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>011-19-0759</b> <b>17. INFORMANT</b> <b>William Hall</b> <b>ADDRESS</b> <b>41 E. 20th St</b></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p>		<p><b>CAUSE OF DEATH</b> <b>Possible Myocardial Infarction</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE</b> <b>ASCVD</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b></p>	
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>12-2</b> <b>1971</b> <b>to</b> <b>5-22</b> <b>1972</b> <b>that (I) (we) last saw the deceased alive on</b> <b>19</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>Manuel A. Gongon, M.D.</b> <b>DEGREE</b></p>		<p><b>23B. DATE SIGNED</b> <b>8-17-72</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>MANUEL A. GONGON M.D.</b> <b>DEGREE</b></p>		<p><b>23D. ADDRESS</b> <b>CHURCH HOME &amp; HOSP - 100 N. BROADWAY</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>24B. DATE</b> <b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>24D. LOCATION</b> (City, town, or county) (Signed)</p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>25B. NAME OF REGISTRAR</b> <b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b></p>	
<p><b>24A.</b> <b>Burial</b> <b>24B.</b> <b>8-25-72</b> <b>24C.</b> <b>McCahey Court</b> <b>24D.</b> <b>St. A. County Md</b></p>		<p><b>25A.</b> <b>AUG 22 1972</b> <b>25B.</b> <b>Frederick H. ...</b> <b>25C.</b> <b>... 100 N. Broadway</b></p>	

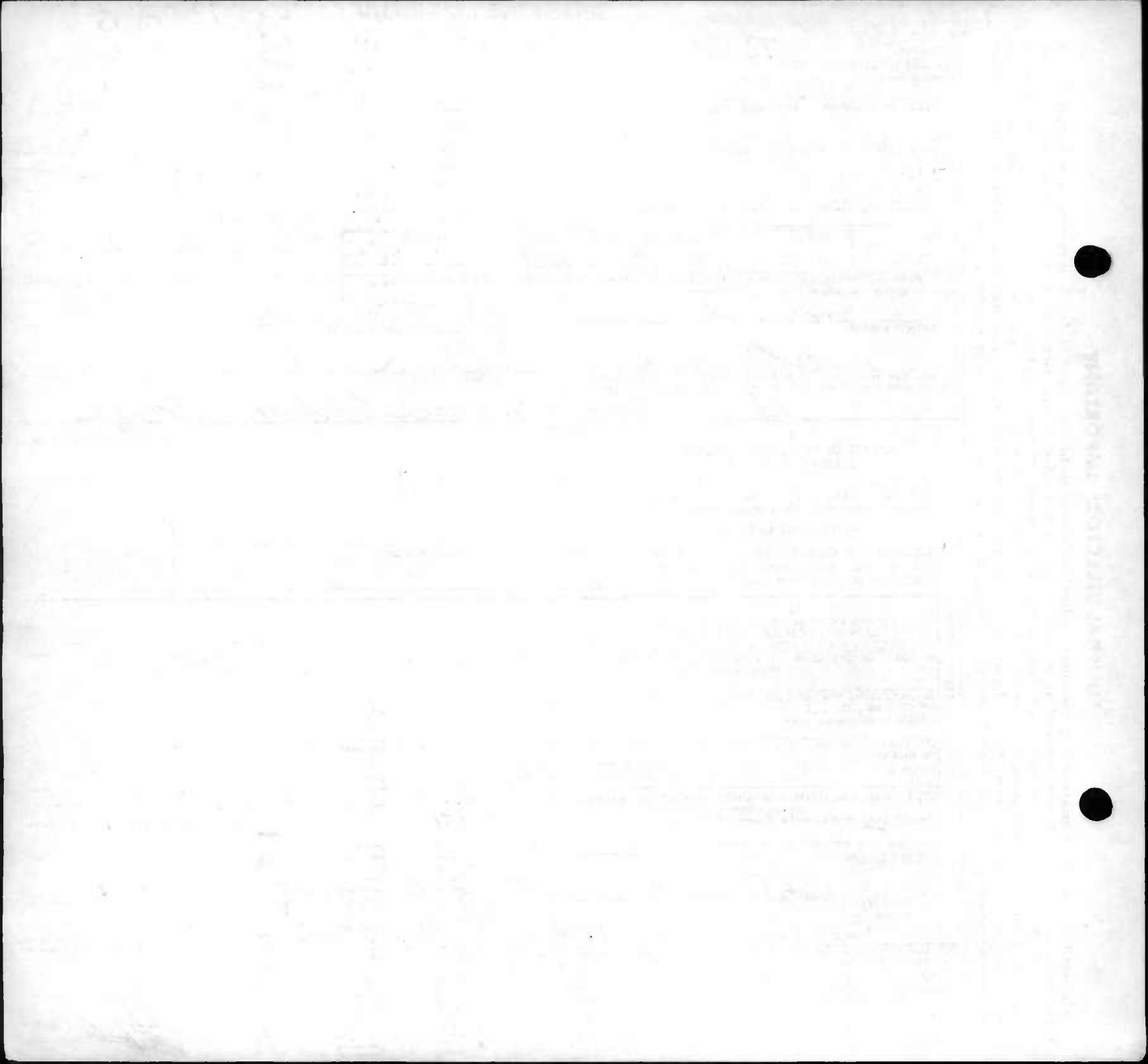




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BALTIMORE CITY HEALTH DEPARTMENT				72 08005
G-650 72 08005				REG. NO.
BIRTH NO.				STATE OF MARYLAND-DEMD
1. NAME OF DECEASED (Type or Print) <b>ALBERT J. GREEN</b>		2. DATE AND HOUR OF DEATH <b>8/22/72</b> <b>1200 A.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 The Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>833</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1321 N. Port Street</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/16/99</b>	9. AGE (In years last birthday) <b>72</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-8344</b>		17. INFORMANT <b>Grace Lurda</b> ADDRESS <b>Same</b>
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CUA</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CUA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>July 17 1972</b> to <b>August 22 1972</b> that (I) (we) lost saw the deceased alive on <b>August 22 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Frederick L. Ferras III MD</b> DEGREE <b>MD</b> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>8/22/72</b>
23C. PHYSICIAN'S NAME (Type) <b>FREDERICK L. FERRAS III MD</b>		23D. ADDRESS <b>Johns Hopkins Hospital 601 N. Broadway Baltimore</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-26-72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Catholics Conf</b>	24D. LOCATION (City, town, or county) <b>Baltimore</b>	(State) <b>Md</b>
25A. DATE REC'D BY HEALTH DEPT <b>AUG 22 1972</b>	25B. NAME OF REGISTRAR <b>Lidney Johnston</b>	25C. FUNERAL DIRECTOR <b>Edison 1000 Granby Ave</b> ADDRESS		





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08006

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

IVY TYLER

2. DATE OF DEATH Known ☒ Month Day Year Hour  
Estimated ☐ 8 18 72 1:30 P.M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
OR INSTITUTION

Maryland General Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
8 18 72 1:30 P.M.5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

14-02

6. SEX

Female

7. RACE

Neg ro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore City

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

12-18-1889

10. AGE (In years last birthday)

88

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

704 W. Mosher St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James H. Chum

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

None

15. MOTHER'S MAIDEN NAME

Clara Norris

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

210-30-1176

18. INFORMANT

Lillian Belle

ADDRESS

Home

19.

412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Arteriosclerotic Cardiovascular DUE TO, OR AS A CONSEQUENCE OF:

Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S

NAME (Type)

W P Mulloy

M.D.

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/19/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-23-72

24C. NAME of CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Baltimore

(State)

MD

25A. DATE REC'D BY HEALTH DEPT.

AUG 22 1972

25B. NAME OF REGISTRAR

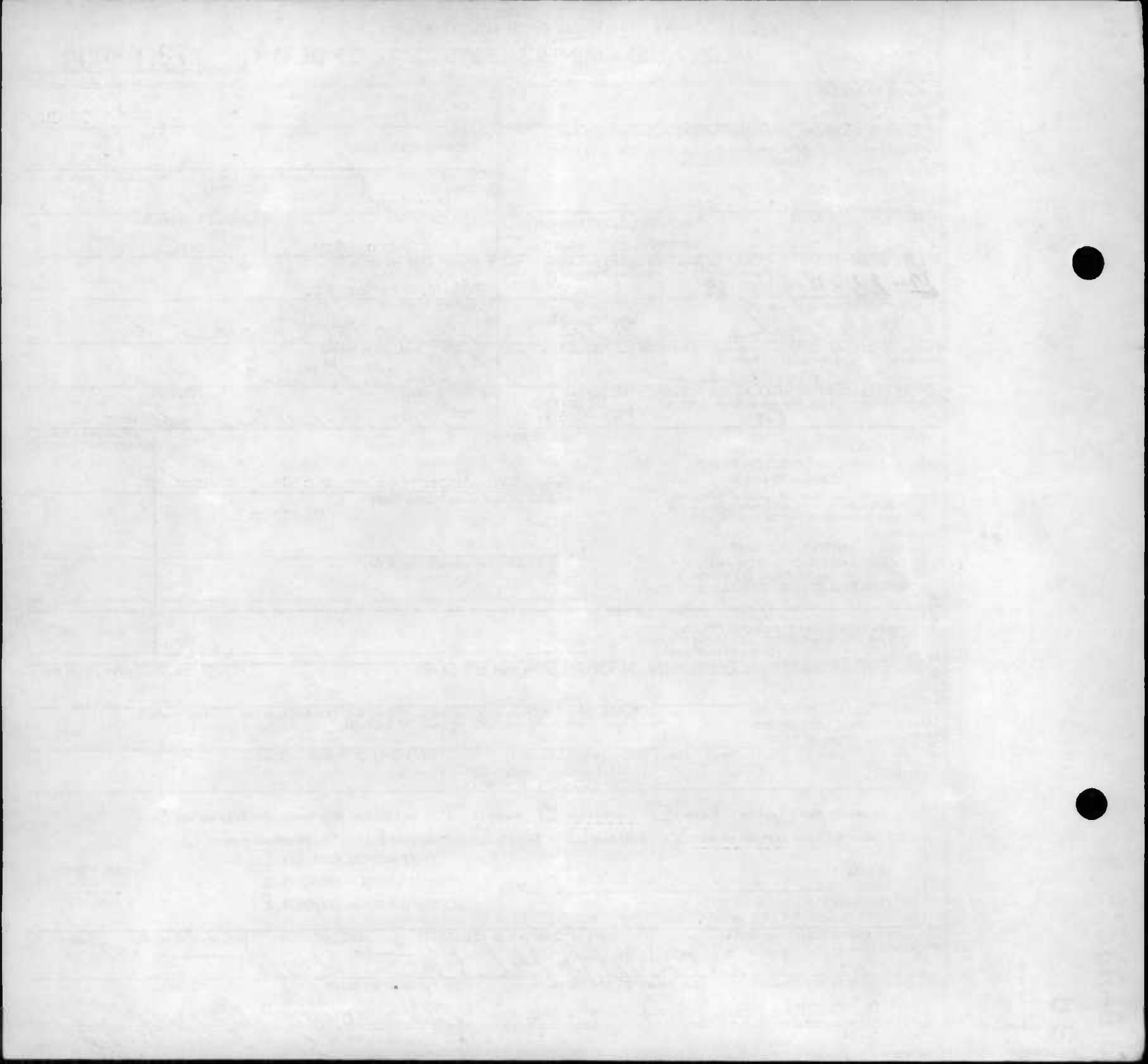
Sidney H. Heston

25C. FUNERAL DIRECTOR

C. H. Heston

ADDRESS

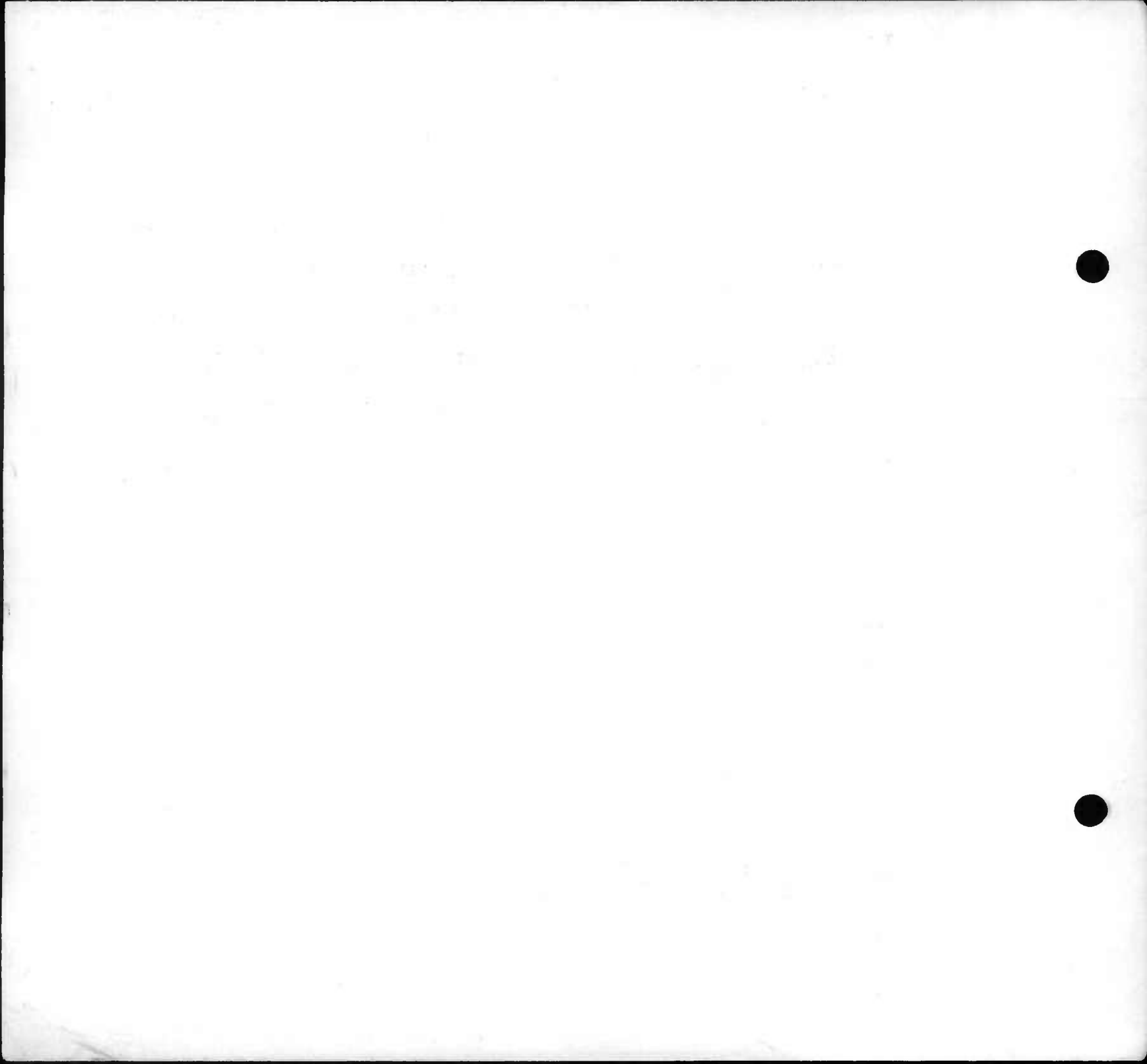
Baltimore



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-600		BALTIMORE CITY HEALTH DEPARTMENT		72 08007	
BIRTH NO.		72 08007		72 08007	
1. NAME OF DECEASED (Type or Print)		LOUIE PERRY		2. DATE AND HOUR OF DEATH 8/19/72 1 35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 1608	
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 1908 ? 9. AGE (in years last birthday) 60 ? 10. BIRTHPLACE (State or foreign country) North Carolina 11. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Howard H. Harpail		14. MOTHER'S MAIDEN NAME Aurora Street		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Pauline Pettit		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GRAM NEGATIVE SEPSIS (B) CARDIO MYOART. OR PERICARDIAL TAMPONADE (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/11/72 19 to 8/19/72 19 that (I) (we) last saw the deceased alive on 8/19/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Robert S. London, M.D.		23B. DATE SIGNED 8/19/72	
23C. PHYSICIAN'S NAME (Type) ROBERT S. LONDON, M.D.		23D. ADDRESS SINAI HOSP OR BALTO.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 8-23-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cal.		24D. LOCATION (City, town, or county) (State) Balto Md.	
25A. DATE REC'D IN HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Dorothy M. Norton		25C. FUNERAL DIRECTOR Korodickson 1007	
25D. ADDRESS Baltimore		25E. ADDRESS Baltimore		25F. ADDRESS Baltimore	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08008

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DOROTHEA DRUMM</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 10:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Sinai Hosp.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 10:30 P.M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore City	
9. DATE OF BIRTH OCT. 15, 1956		10. AGE (In years last birthday) 15	
11. BIRTHPLACE (State or foreign country) PITTSBURGH, PA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR CHARLES DRUMM SR.		14. MOTHER'S MAIDEN NAME WILLIAM REGINA LOVE	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. DATE OF BIRTH OCT. 15, 1956		17. AGE (In years last birthday) 15	
18. BIRTHPLACE (State or foreign country) PITTSBURGH, PA		19. CITIZEN OF WHAT COUNTRY? U.S.A.	
20. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		21. KIND OF BUSINESS OR INDUSTRY PITTSBURGH HIGH SCHOOL	
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO		23. SOCIAL SECURITY NO. NONE	
24. INFORMANT ADDRESS		25. ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. IMMEDIATE CAUSE Multiple Traumatic Injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Md. St. Rt. 140 at Warren Rd. Balt. Co.		22D. HOW DID INJURY OCCUR? pedestrian struck by car	
22D. TIME OF INJURY (APPROX.) 8/18/72 8:55 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 8/19/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Aug. 22 1972	
24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN CEMETERY		24D. LOCATION (City, town, or county) (State) GLEN BURNIE Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Adrian W. Hinton	
25C. FUNERAL DIRECTOR Frank H. Newell		25D. ADDRESS Pikesville, Md.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-323		72 08009		BALTIMORE CITY HEALTH DEPARTMENT		72 08009	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) PATCHETT, EDITH HOWASEN				2. DATE AND HOUR OF DEATH AUGUST 21, 1972 12:20 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND BALTIMORE COUNTY		5300	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09 27 89	
9. AGE (In years last birthday) 82		10. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN BAYLISS		14. MOTHER'S MAIDEN NAME SOPHIA (GREEN)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705-05-6019	
17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CENTRAL FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral vascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from AUGUST 18, 1972 to AUGUST 21, 1972, that (X) (we) last saw the deceased alive on AUGUST 21, 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kuang-Yen Huang				23B. DATE SIGNED 08 21 72			
23C. PHYSICIAN'S NAME (Type) KUANG-YEN HUANG, M.D.				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial Aug 23 1972		Aug 23 1972		Daniel Ridge Cemetery, Pikesville, Balt MD			
25A. DATE REC'D BY HEALTH DEPT. AUG 22 1972		25B. NAME OF REGISTRAR Henry H. Newell, Jr.		25C. FUNERAL DIRECTOR Frank H. Newell, Inc.		ADDRESS 1100 R. Eastman Rd.	



1:30 A

DATE: 11/11/58

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UNIVERSITY

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ST. LOUIS HOSPITAL

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

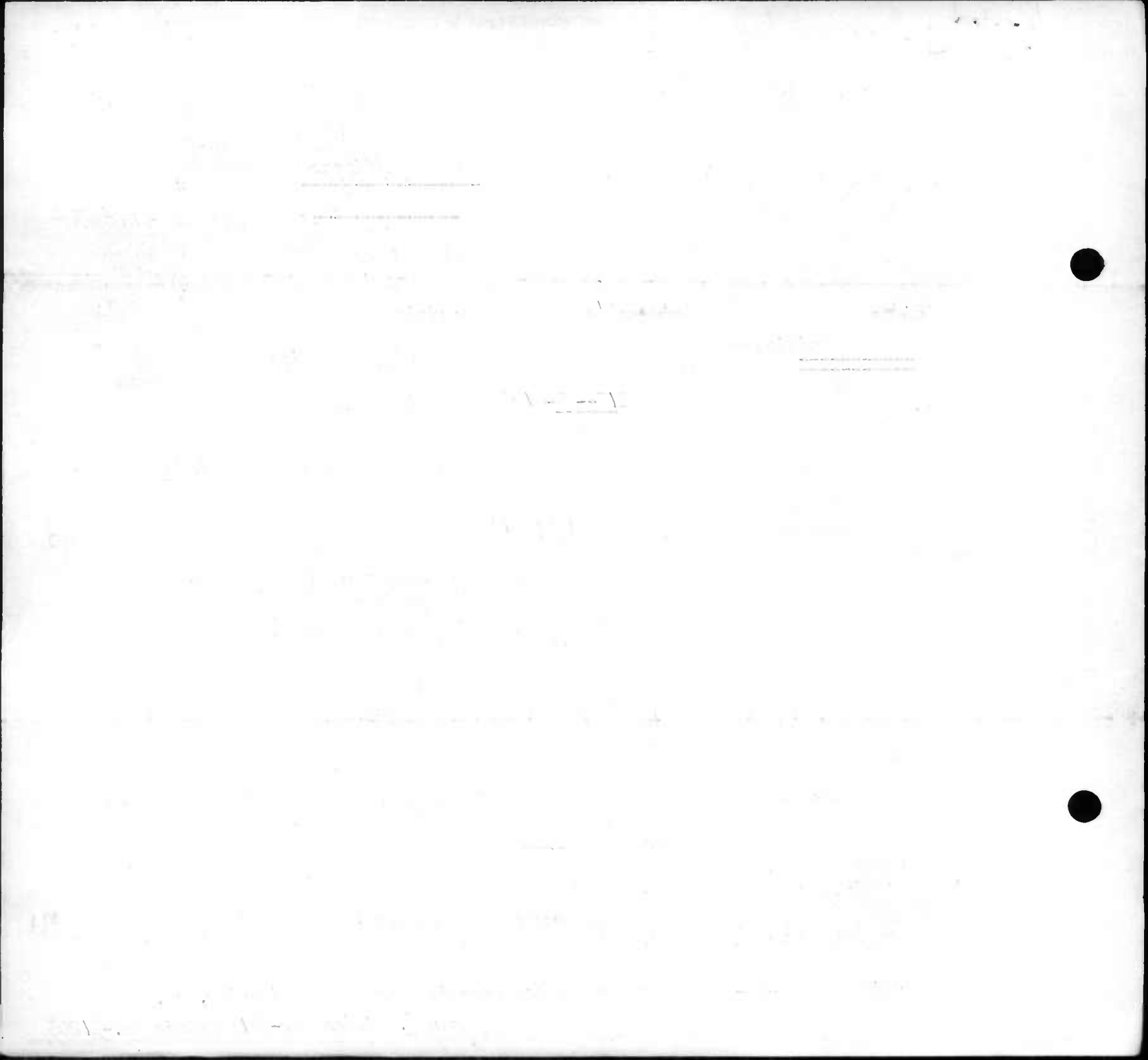
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08010</u>	
M-008 72 08010				STATE OF MARYLAND-DEPT	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lillian Mayo</u>				8/17/72 5:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY</u>				1836 N. DURHAM STREET BALTIMORE, MD. 21213	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>6/7/24</u> 9. AGE (In years last birthday) <u>48</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>JACK BROWN</u>				14. MOTHER'S MAIDEN NAME <u>PEARL BENSON</u> 21205 E. HOFFMAN ST. BALT. MD.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-14-5905</u>	
17. INFORMANT <u>PEARL BARD</u> 2005 E. HOFFMAN ST. BALT. MD.				ADDRESS <u>21205</u>	
18. <u>571.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia, septicaemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hepatic coma, liver cirrhosis</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>± 8 hrs</u> <u>± 24 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> 19 <u>72</u> to <u>8/17</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>8/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William B. Spicer MD</u> DEGREE				23B. DATE SIGNED <u>8/17/72</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/22/72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. AUBURN CEMETARY</u>	
24D. LOCATION (City, town, or county) (State) <u>MT. AUBURN CEM. MT. WINANS MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 22 1972</u>			
25B. NAME OF REGISTRAR <u>Sidney W. H. H. H.</u>		25C. FUNERAL DIRECTOR <u>WILLIAM J. SPICER</u> 1639 N. BROADWAY			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

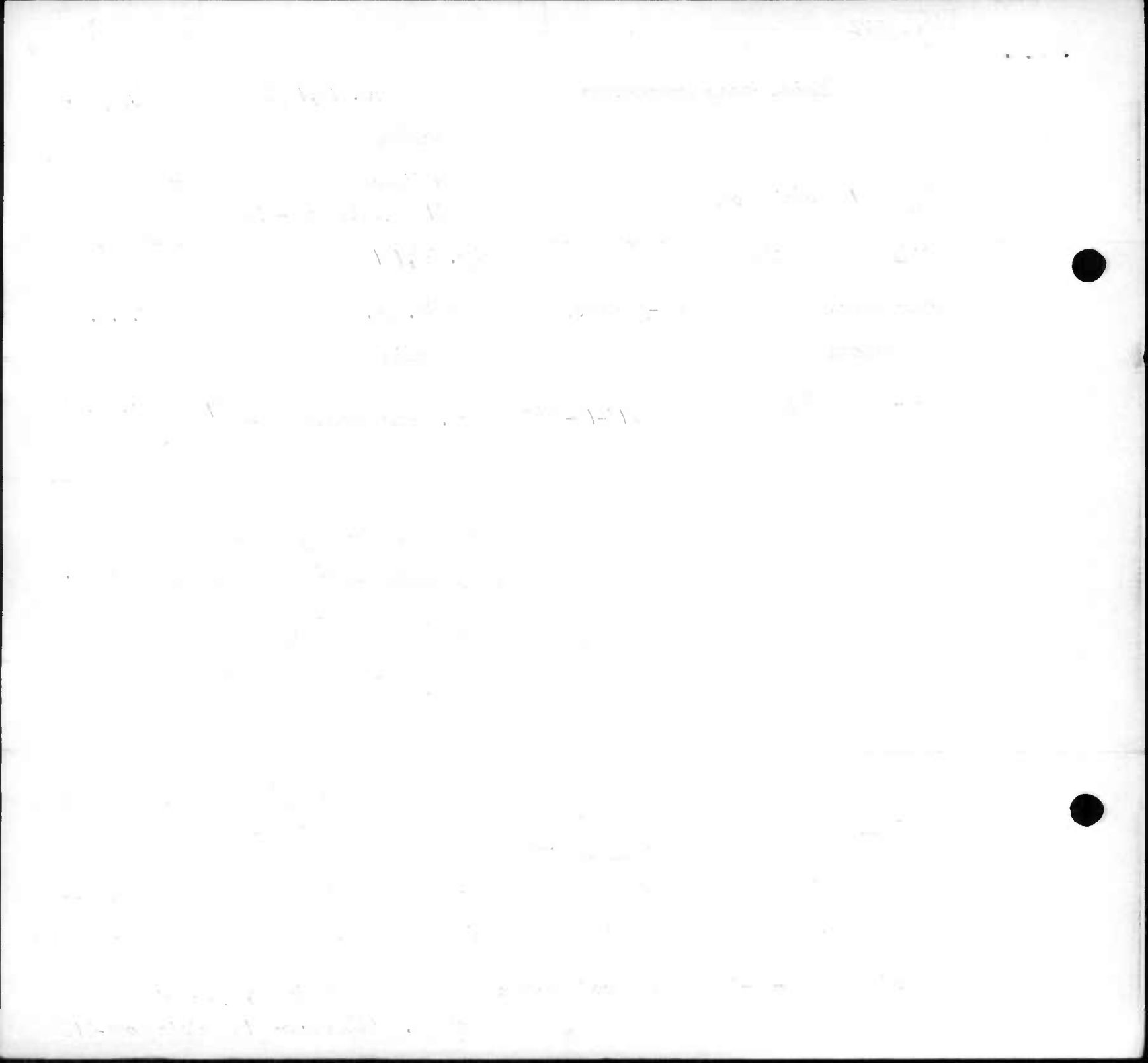
J-620 72 080111		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 080111	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Frank Jirsa</u>		2. DATE AND HOUR OF DEATH <u>8/18/72</u> <u>2:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>		E. STREET AND NUMBER <u>Lutherette 1626 E 31st St.</u>			
5. SEX <u>male</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/88</u>	9. AGE (In years last birthday) <u>83</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Kavanagh's</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Matthias Jirsa</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jirsa</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2170-07-5103</u>		17. INFORMANT <u>Chart.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio pulmonary Arrest. Opine</u> (B) <u>CVA.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Atherosclerotic Cardiovascular Disease</u> <u>Chronic Obstructive Pulm disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <u>Aug. 18 2:00pm</u> 19 <u>72</u> to <u>Aug 18 2:30pm</u> 19 <u>72</u> that (B) (we) last saw the deceased alive on <u>Aug. 18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (C) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Raymond J Bauzys MD</u>		23B. DATE SIGNED <u>8/18/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Raymond J Bauzys MD</u>	
23D. ADDRESS <u>5 Danhurst Court Towson, Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-22-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Memorial Park</u>	
24D. LOCATION <u>Timonium, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>			
25B. NAME OF REGISTRAR <u>Sidney Johnson</u>		25C. FUNERAL DIRECTOR <u>John C. Miller Inc 6415 Belair Rd. - 21206</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-526</b>      <b>72 08012</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>72 08012</b></p> <p style="font-weight: bold;">STATE OF MARYLAND-DHMH</p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <i>Daniel Harry Baumgartner</i></p>		<p>2. DATE AND HOUR OF DEATH <i>Aug. 19, 1972</i>      <i>3:30 A.</i> M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>00 6510 Belair Road</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <i>Maryland</i>      B. COUNTY <i>2745</i></p> <p>C. CITY OR TOWN <i>Baltimore</i>      D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <i>6510 Belair Road-21206</i></p>	
<p>5. SEX <i>M</i>le</p>	<p>6. RACE <i>White</i></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <i>Dec. 22, 1916</i></p>
<p>9. AGE (In years last birthday) <i>55</i></p>		<p>If Under 1 Yr. Months:      Days:      If Under 24 Hrs. Hours:      Min.</p>	<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tavern Owner</i></p>
<p>10B. KIND OF BUSINESS OR INDUSTRY <i>Self-Employed</i></p>		<p>11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i></p>	<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>
<p>13. FATHER'S NAME <i>Unknown</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Amelia</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>Yes- WWII</i></p>		<p>16. SOCIAL SECURITY NO. <i>215-10-5047</i></p>	<p>17. INFORMANT ADDRESS <i>Mrs. Mary Baumgartner- 6510 Belair Road</i></p>
<p>18. <i>410.9 I + 250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <i>0</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) <i>NO</i></p>
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>1-11-1965</i> to <i>19 Aug 1972</i> that (H) (we) lost saw the deceased alive on <i>8-14-1972</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>John C. Hyler</i></p>		<p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>	<p>23B. DATE SIGNED <i>8-21-72</i></p>
<p>23C. PHYSICIAN'S NAME (Type) <i>JOHN C. HYLER</i></p>		<p>23D. ADDRESS <i>7527 Belair Rd Balto 21236 Md</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>	<p>24B. DATE <i>8-22-72</i></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i></p>	<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <i>AUG 23 1972</i></p>	<p>25B. NAME OF REGISTRAR <i>Disney Houston</i></p>	<p>25C. FUNERAL DIRECTOR ADDRESS <i>John C. Hyler Inc-6415 Belair Road-21206</i></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08013		72 08013	
C-143				72 08013		72 08013	
BIRTH NO.				72 08013		72 08013	
1. NAME OF DECEASED (Type or Print) <b>Philomena Capiletto</b>				2. DATE AND HOUR OF DEATH <b>August 14, 1972 6:40 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. AGNES HOSPITAL Wilkens and Caton Ave. Baltimore, Maryland 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore County</b> C. CITY OR TOWN <b>Baltimore County</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>329 Harlem Lane, Caton Ridge Nursing Home</b>			
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 January 88</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Andrew Scarmazza</b>				14. MOTHER'S MAIDEN NAME <b>Lucia</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Dorothy Erdbrink 1314 Limit Avenue 21239</b>			
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <b>12-24-71</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary Emboli</b> (B) <b>arteriosclerotic cardiovascular disease</b> (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>E. Henzan M.D.</b>				23B. DATE SIGNED <b>8/15/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>EITATSU HENZAN</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>17 Aug 72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Scarmazza</b>		25C. FUNERAL DIRECTOR <b>Burge Funeral Home,</b>		ADDRESS <b>Baltimore, Md.</b>	

7/17/72

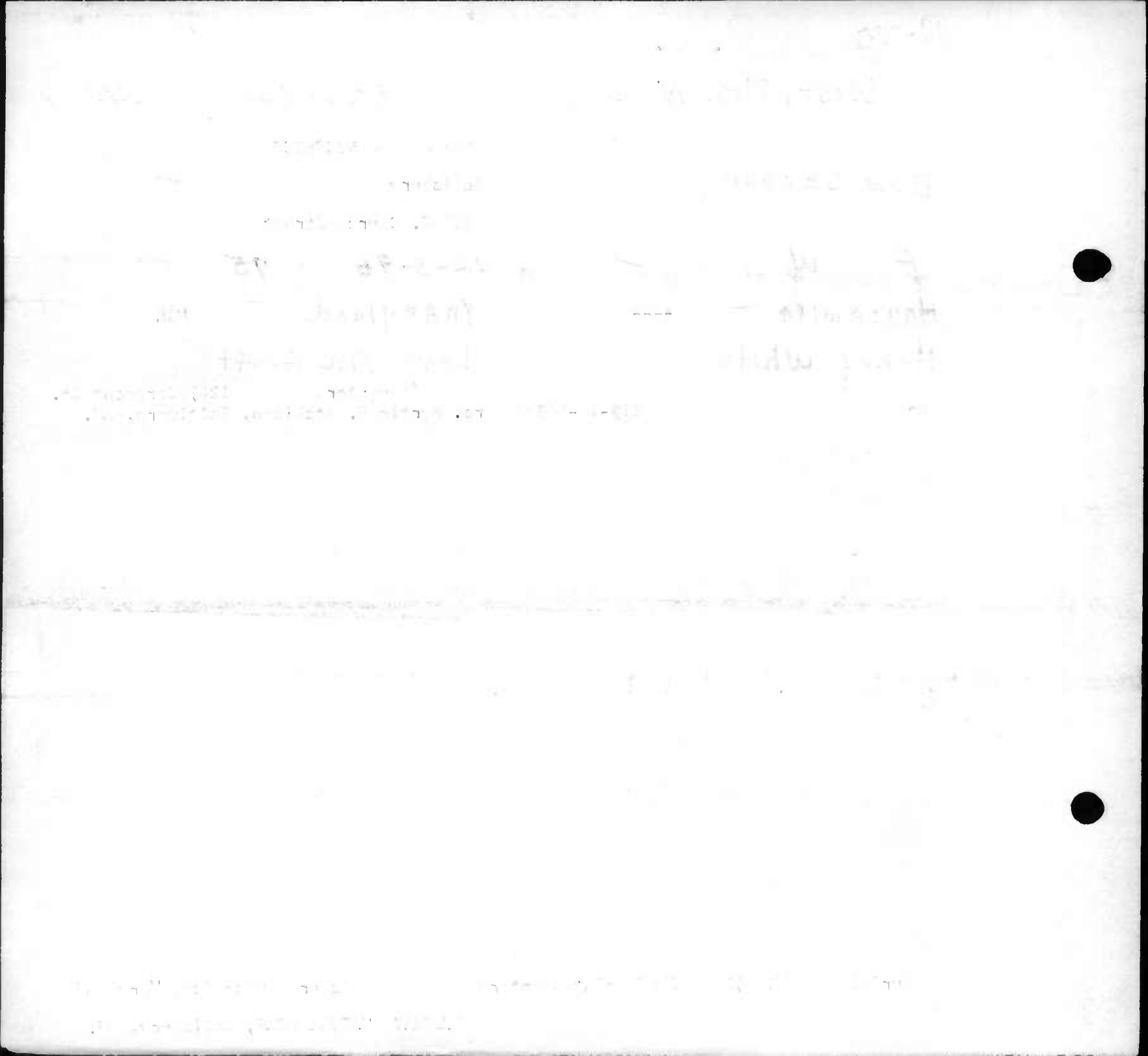
2809 Miles Ave 21211



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

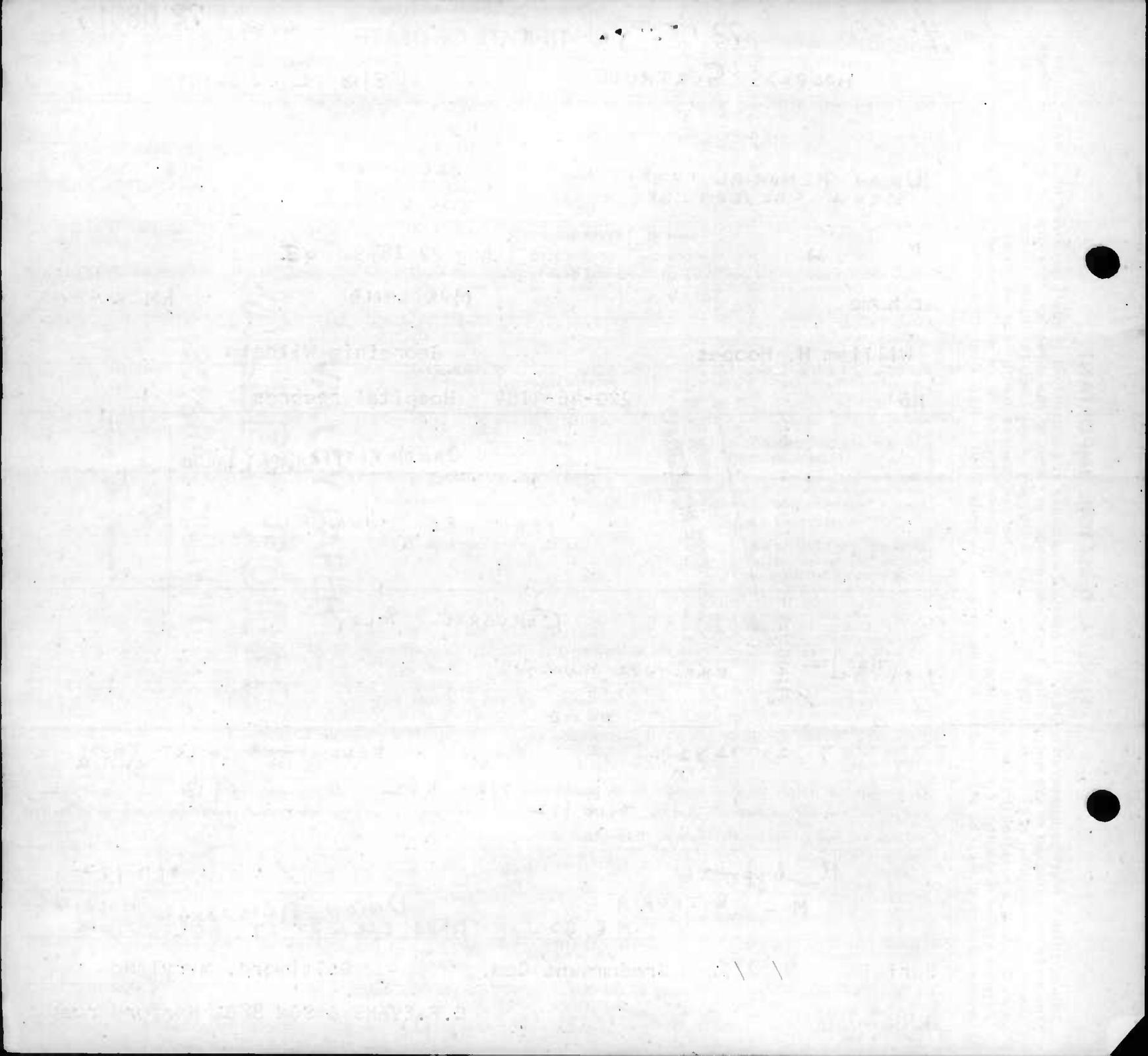
BALTIMORE CITY HEALTH DEPARTMENT		72 08014		72 08014	
W-230		72 08014		72 08014	
BIRTH NO.		REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
West, Mrs. Nora W.		8-16-72		6:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
Bon Secour		Md.		WICOMICO	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
34		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		613 E. Church Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-3-96	75	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		----		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry White		Levi McGraft		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-14-6639		(Daughter) 1207 Sargeant St.	
				Mrs. Myrtle E. Atchison, Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 12 19 72 to Aug 16 19 72 that (I) (we) last saw the deceased alive on Aug 16 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
C. J. Ahn		Aug 16 72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
CHOON Ja Ahn		Bon Secours Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/19/72		Shad Point Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Salisbury, Wicomico, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 23 1972		D. J. H. H. H.		HOLLOWAY FUNERAL HOME, Salisbury, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

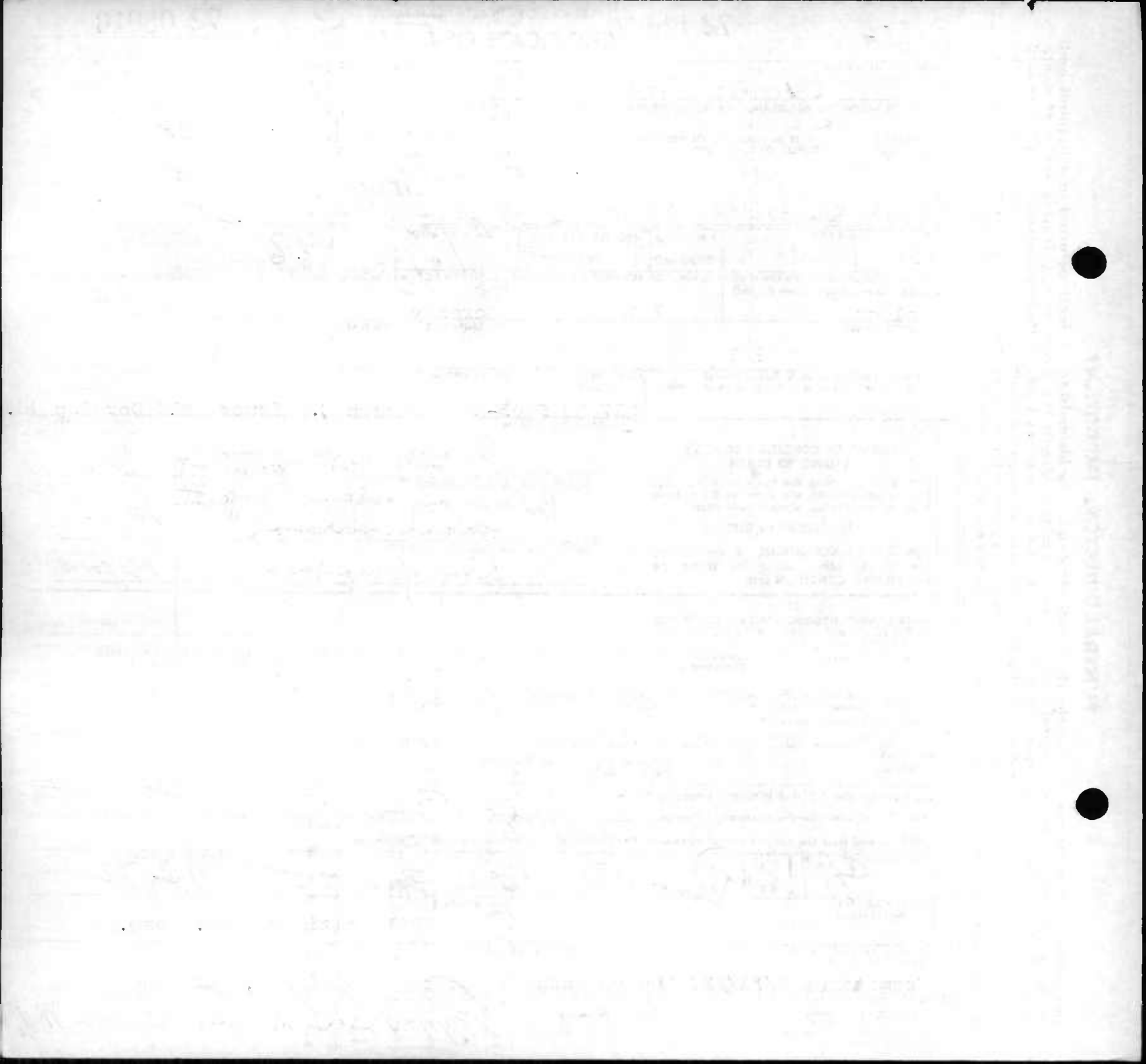
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08015	
BIRTH NO. H-120		72 08015		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) HOOPES, GERTRUDE			2. DATE AND HOUR OF DEATH 8/18/72 - 2:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 33RD & CALVERT ST.			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY 1202 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER HOMEWOOD APTS. 3150 & CHARLES ST 21218		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 22 1879	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME William H. Hoopes			14. MOTHER'S MAIDEN NAME Georgina Wilhelm		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-46-3184	17. INFORMANT ADDRESS Hospital records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSE DISEASES OR CONDITIONS which gave rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CEREBRAL PALSY			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO RESPIRATORY FAILURE PULMONARY EMBOLUS FRACTURE HUMERUS. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 8/17/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE HUMERUS		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7 23 72 8:20 PM		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In bathroom 12-02	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL FROM TOILET FROM CHAIR			
22. I certify that (I) (this hospital) attended the deceased from 7/24/72 to 8/18/72, that (I) (we) last saw the deceased alive on 8/18/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. L. B. B. B.			23B. DATE SIGNED 8/18/72		
23C. PHYSICIAN'S NAME (Type) M. L. B. B. B.			23D. ADDRESS UNION MEMORIAL HOSPITAL 33RD & CALVERT ST BALT 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/22/72	24C. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1972		25B. NAME OF REGISTRAR G. F. EVANS & SON		25C. FUNERAL DIRECTOR ADDRESS 8802 Harford road	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

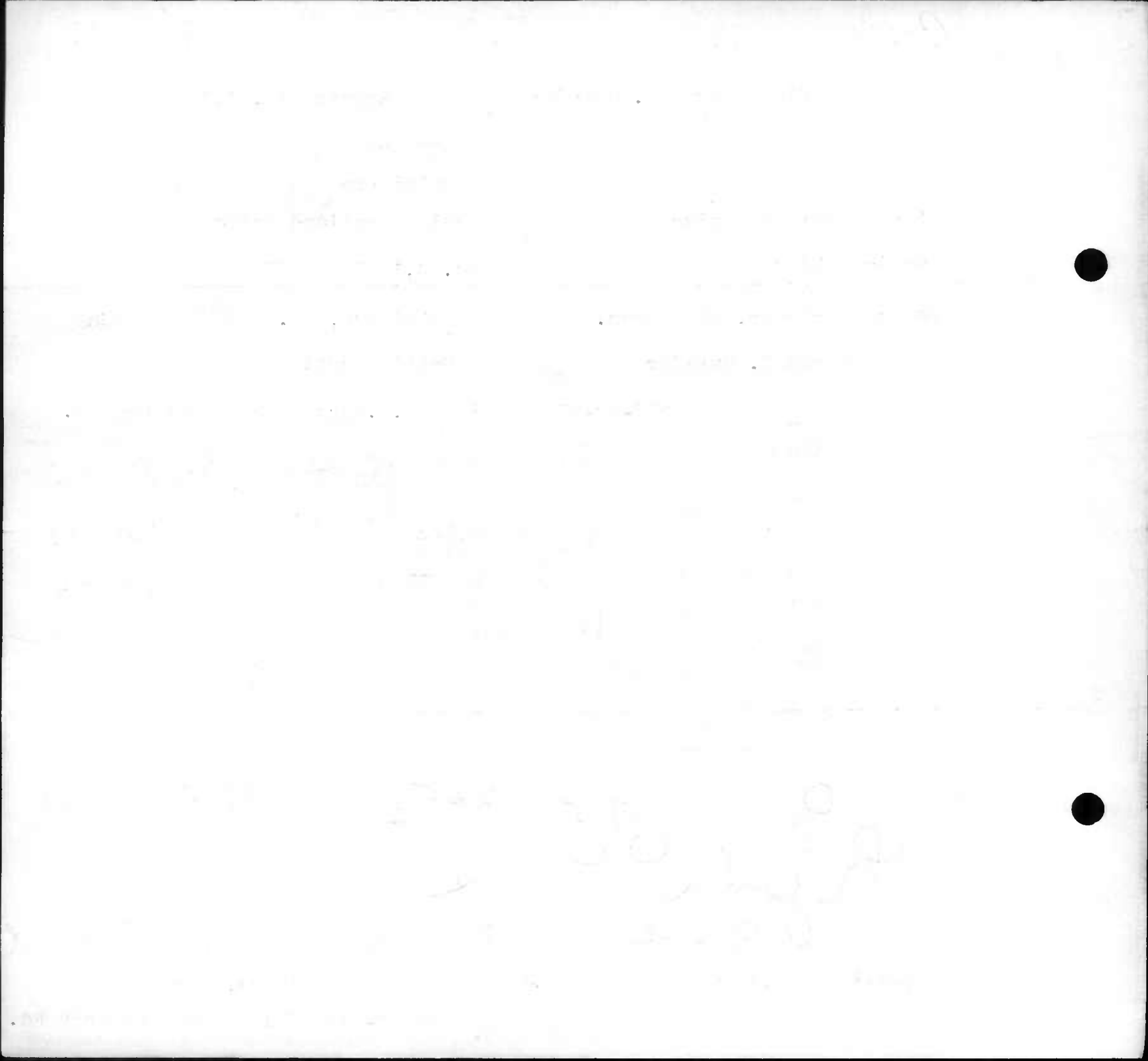
Baltimore City Health Department				REG. NO. 72 08016	
B-656 72 08016				STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO.				DEATH NO.	
1. NAME OF DECEASED (Type or Print) <u>Birner, Joseph</u>			2. DATE AND HOUR OF DEATH <u>8/19/72</u> <u>1:05 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Balto. Gen. Hosp.</u>			A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>8/10/06</u> 9. AGE (In years last birthday) <u>66 yrs</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>			11. BIRTHPLACE (State or foreign country) <u>Germany</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>??</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>???</u>			14. MOTHER'S MAIDEN NAME <u>???</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217 18 596B-A</u>		
17. INFORMANT <u>Joseph C. Birner</u>			ADDRESS <u>915 Dorking Rd.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Probable acute myocardial infarction</u> <u>3 hrs.</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic pulmonary edema, congestion</u> <u>20 years.</u>		
			(C) <u>History of hypertension</u> <u>10 years.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 Aug 1972</u> to <u>19 Aug 1972</u> that (I) (we) last saw the deceased alive on <u>19 Aug 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D. DEGREE				23B. DATE SIGNED <u>19 Aug 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>South Baltimore Gen. Hosp.</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<u>Cremation</u>		<u>8/21/72</u>		<u>Loudon Park Crematory</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>	
25D. ADDRESS		25E. ADDRESS			





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C-326		72 08017		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08017	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Miss Mary R. Cutajar				August 15, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00				Maryland			
2301 Pentland Drive				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				Baltimore			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				2301 Pentland Drive			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Apr. 14, 1885	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
87		Retired Trimmer, Lion Bros.		Baltimore, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph T. Cutajar				Nellie Scott			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				217-09-1784		Miss F.E. Marzak 2301 Pentland Dr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				B. DUE TO, OR AS A CONSEQUENCE OF:		years	
II				C. DUE TO, OR AS A CONSEQUENCE OF:		years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Underlying malignancy		1 year	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1965 to 8/15 1972 that (I) (we) last saw the deceased alive on 8/15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
U D S H				2061 S. Belvoir Pentland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/19/72		Loudon Park		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 23 1972		Sister W. W. W. W.		Mitchell Wiedefeld		Home 6500 York Rd.	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 08018</b> <small>STATE OF MARYLAND-DEATH</small>
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Marybelle E. Muth		8/19/1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 4411 N. Charles St		A. STATE Md. Baltimore		
		B. COUNTY		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4411 N. Charles St.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1878	9. AGE (in years last birthday) 94
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isaac Elinger		
14. MOTHER'S MAIDEN NAME Isabelle Pollard		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hugh A. Meade same		
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>arteriosclerotic degenerative cardiovascular disease</i> (A) IMMEDIATE CAUSE <i>Peripheral Vascular Insufficiency</i> <i>Circulatory Collapse</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>acute heart failure</i> (C) DUE TO, OR AS A CONSEQUENCE OF:  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 19 1972</u> to <u>19 Aug 1972</u> that (I) (we) last saw the deceased alive on <u>19 Feb. 1972</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did not) view the body after death.		23A. SIGNATURE <i>Joseph E. Muse Jr MD</i>		
23B. DATE SIGNED <u>19 Aug '72</u>		23C. PHYSICIAN'S NAME (Type) <u>29 MS</u>		
23D. ADDRESS <u>901 Pine Hts Ave. Balto.</u>		23E. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/21/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery
24D. LOCATION Frederick Rd. Balto Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 23 1972		
25B. NAME OF REGISTRAR <i>Lidney</i>		25C. ADDRESS 6500 York Rd.		

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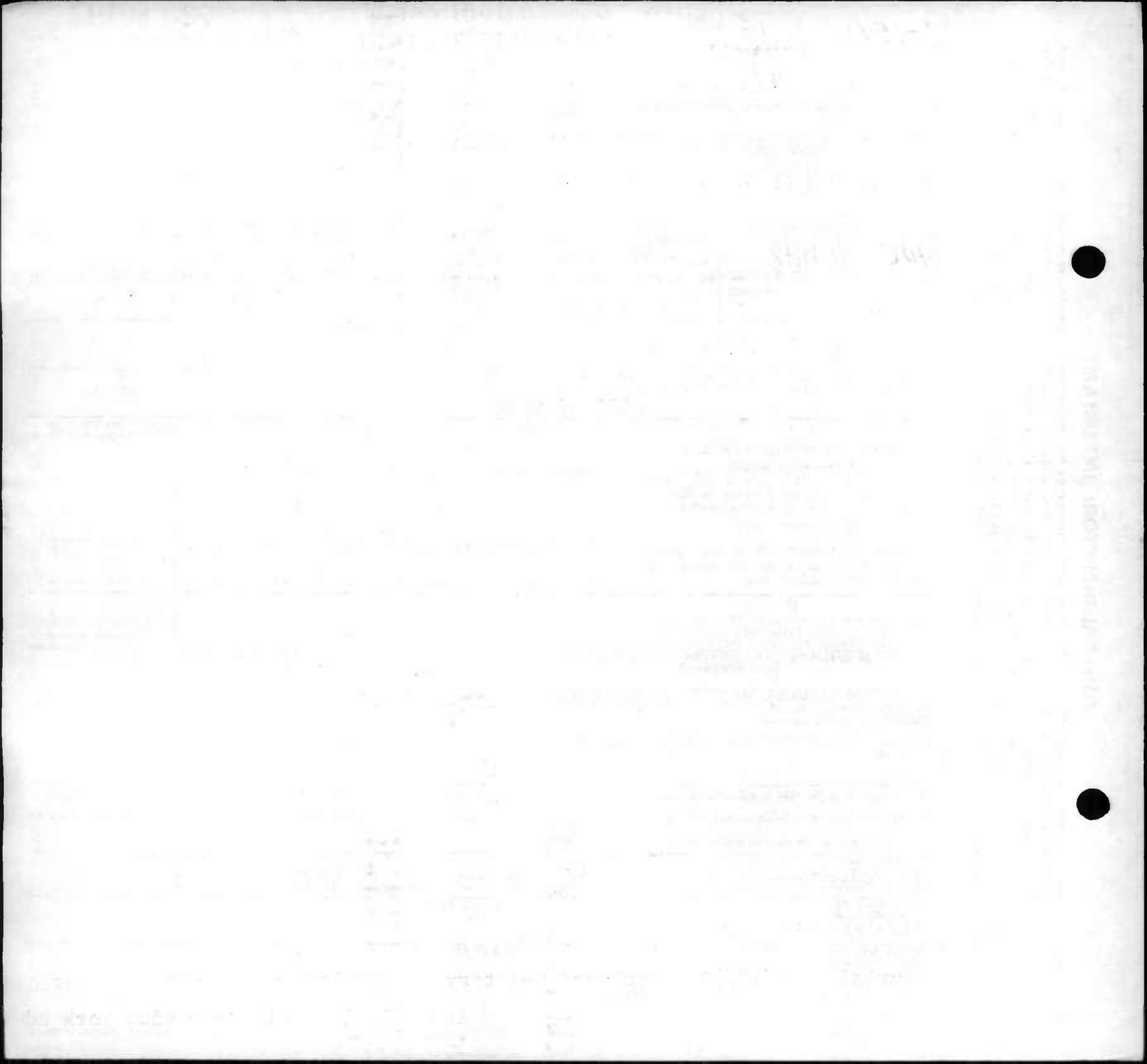
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C-654 72 08019		72 08019	
BIRTH NO. Cromwell		REG. NO. STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) CROMWELL, LAWRENCE P		2. DATE AND HOUR OF DEATH 8/16/72 8 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND U.S.A. 4210 5300 B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 44		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1723 PIN OAK ROAD.			
5. SEX MALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-10-06 66
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
10B. KIND OF BUSINESS OR INDUSTRY Retired?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HENRY		14. MOTHER'S MAIDEN NAME RICE, MARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 07 9624	17. INFORMANT chart
18. 379.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiovascular - respiratory collapse		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic obstructive lung disease (B) DUE TO, OR AS A CONSEQUENCE OF: with CO2 retention and naroxysy (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from 08/16/72 to 8/16/72, that (N) (we) last saw the deceased alive on 8/16/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M. Shocair H.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 8/16/72.
23C. PHYSICIAN'S NAME (Type) MAWYA SHOCAIR MD DEGREE		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8/19/72	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	24D. LOCATION Taylor Ave Balto Md
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1972	25B. NAME OF REGISTRAR Sidney Wharton	25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08020</u>	
B-260 72 08020				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MAGGIE L. BAKER</u>		2. DATE AND HOUR OF DEATH <u>8-19-72</u> <u>1:51</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>FALLS</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MGH 48</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Md General Hosp</u>		C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>ot</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		8. DATE OF BIRTH <u>07-05-92</u> 9. AGE (In years last birthday) <u>80</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Kerr</u>	
14. MOTHER'S MAIDEN NAME <u>FANNIE BONNETT</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>21252 A30</u>	
17. INFORMANT <u>Mrs Thelma Harman</u>		ADDRESS <u>4418 Clydesdale Av</u>			
18. <u>1972</u> I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>cardio-pulmonary arrest</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>probable intracerebral carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) _____			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> 19 <u>72</u> to <u>8-19</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8-19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W H Bouchele MD</u>		23B. DATE SIGNED <u>8-19-72</u>		23C. PHYSICIAN'S NAME (Type) <u>WILLIAM BOUCHELLE MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>22 Aug 72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville Balto Co Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		25B. NAME OF REGISTRAR <u>Indy Wharton</u>	
25C. FUNERAL DIRECTOR <u>Burgess Funeral Home Balto Md</u>		25D. ADDRESS <u>North Washington St</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-400		72 08021		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08021	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
EDNA M. OHL				August 19, 1972 1:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
90 The Wesley Home, Inc 2211 West Rogers Avenue				Maryland			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				2211 West Rogers Avenue			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		April 9, 1885	
						9. AGE (In years lost birthday)	
						87	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
				Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John OHL				Alverta A. Schaefer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				212 10 3235 A		The Wesley Home Inc same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Intervascular Cardiovascular Disease			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
O				No			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 21 July 1972 to 19 August 1972, that (I) (we) last saw the deceased alive on 17 August 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John W. Barnaby				22 Aug 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. John W. Barnaby				1652 E. Belvedere Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		22 Aug 72		Woodlawn Cemetery		Woodlawn, Balto Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 23 1972		Dorothy M. Hinton		Burgess Funeral Home, Baltimore, Maryland			
By: Susan M. Banya Jr							



7/24/69

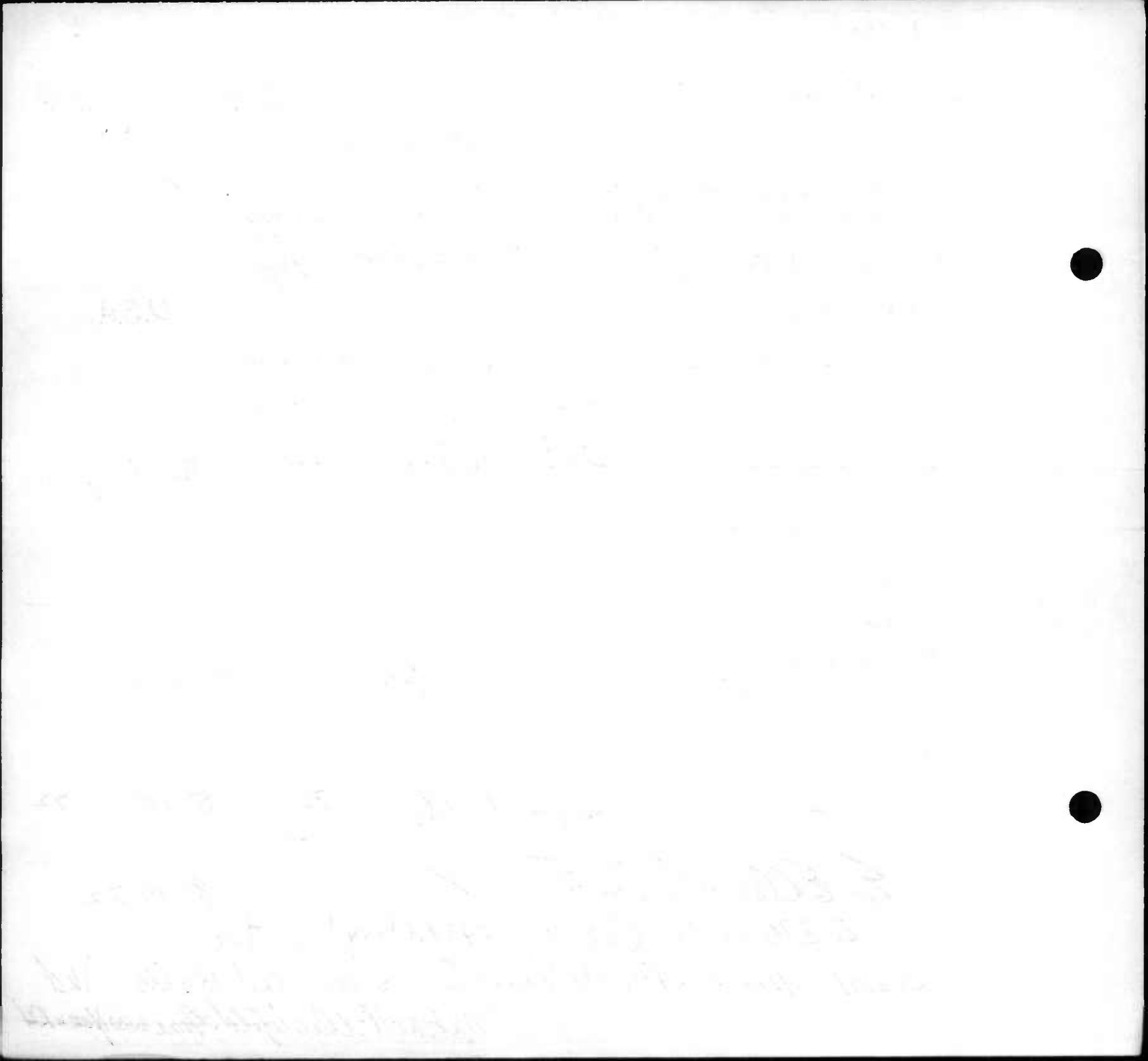
808 Benninghaus Rd 21212

OT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-520		72 08022		BALTIMORE CITY HEALTH DEPARTMENT		72 08022	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND - DHHH	
1. NAME OF DECEASED (Type or Print) <i>Bridgett Owens</i>				2. DATE AND HOUR OF DEATH <i>8/18/72 4:20 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bolton Hill Nursing &amp; Convalescent Center</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2711</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>4408 Greenway</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-28-78</i>	9. AGE (In years last birthday) <i>93 yrs</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Thomas Owens</i>			14. MOTHER'S MAIDEN NAME <i>Bridget Moorhan</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>220-30-2701</i>		17. INFORMANT <i>Admission Record</i>		
18. <i>440.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>arteriosclerosis</i> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several years</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (f) (this hospital) attended the deceased from <i>1-18-1972</i> to <i>8-18-1972</i> that (l) (we) last saw the deceased alive on <i>8-17-1972</i> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (l) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. Ellsworth Cook MD</i>				23B. DATE SIGNED <i>8-19-72</i>		23C. PHYSICIAN'S NAME (Type) <i>E. Ellsworth Cook MD</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/21/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Frederick Rd Balto Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 23 1972</i>		25B. NAME OF REGISTRAR <i>Lidney</i>		25C. FUNERAL DIRECTOR <i>Mitchell</i>		ADDRESS <i>Wiedefeld Lane 6500 York Rd</i>	



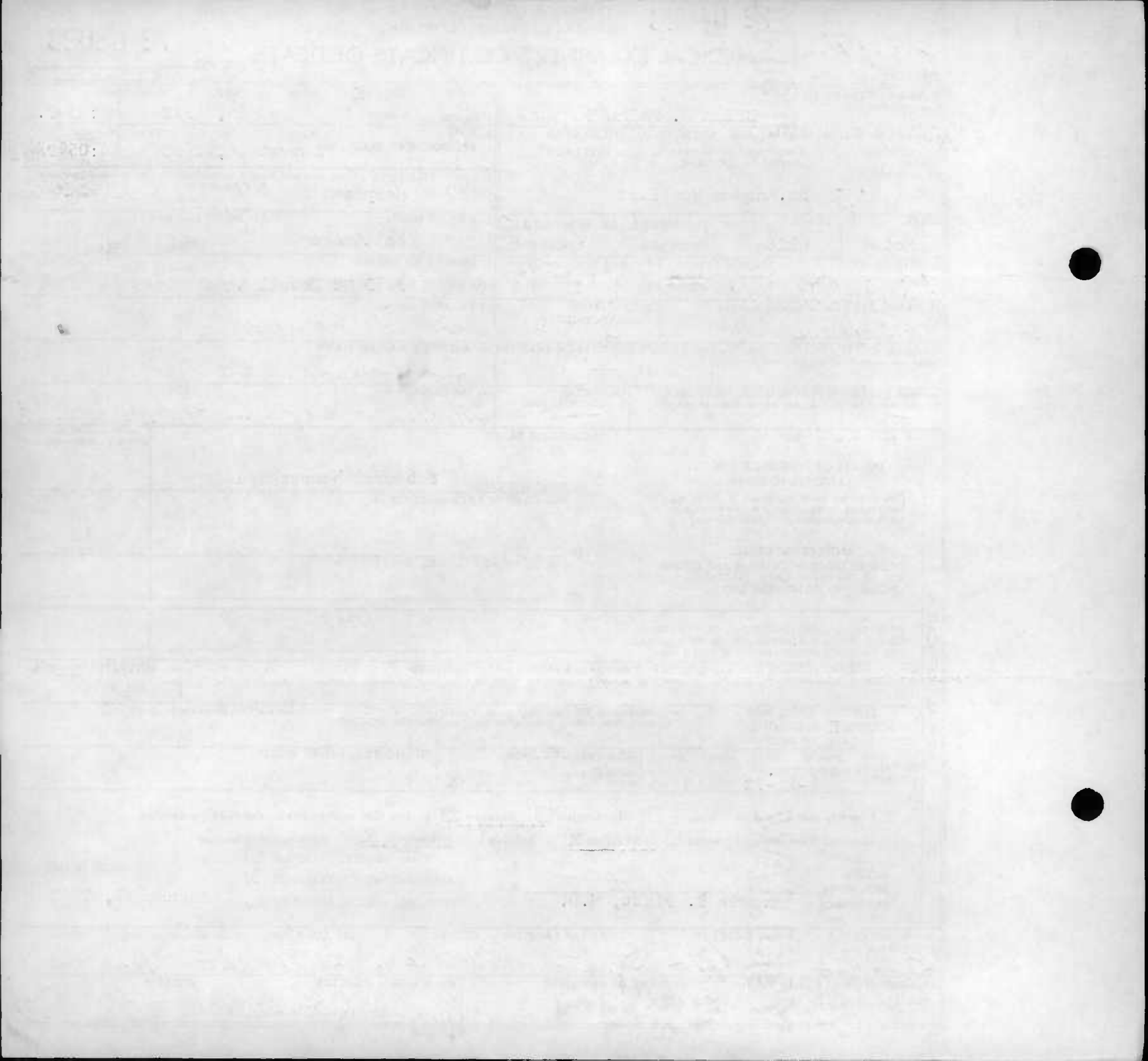
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 71-07002

1. NAME OF DECEASED (Type or Print) <b>BRIAN M. FAIRLEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 16, 1972 Hour: 4:05 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour August 16, 1972 4:05 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH <b>APR. 19 1971</b>		10. AGE (in years lost birthday) <b>7 YR. 7 Mths</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>CHARLES FAIRLEY JR.</b>		15. MOTHER'S MAIDEN NAME <b>SUSAN GRIMES</b>	
18. INFORMANT <b>CHARLES FAIRLEY JR.</b>		ADDRESS <b>3713 Mc Dowell La.</b>	

19. CAUSE OF DEATH <b>E9229 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Subdural hemorrhage DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>?</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>?</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>approx. 8-11-72 ? m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>?</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <b>Marvin S. Platt, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): <b>Marvin S. Platt, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>August 17, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/19/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Raymond L. Kaczorowski</b>	
25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>		ADDRESS <b>2525 FLEET ST BALTO, MD.</b>	



72 08024

STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08024

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Leona Welch</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 20 72 9:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>100 108 S. Carlton Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 20 72 9:45 p.m.	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>8/21/1909</b>		10. AGE (In years lost birthday) <b>62</b>	
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Welch</b>		14. MOTHER'S MAIDEN NAME <b>Offie ?</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		16. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO. <b>241-22-5618</b>	
19. CAUSE OF DEATH <b>412.4</b>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>8/23/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. Fisher</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-21-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>8/23/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Glenburne, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Sidney S. Fisher</b>	
25C. FUNERAL DIRECTOR <b>John J. Cowan, Jr., Inc.</b>		ADDRESS <b>901 Mallon St. Balt. Md.</b>	

100 S. Carlton Street

Chicago, Illinois

100 S. Carlton St.

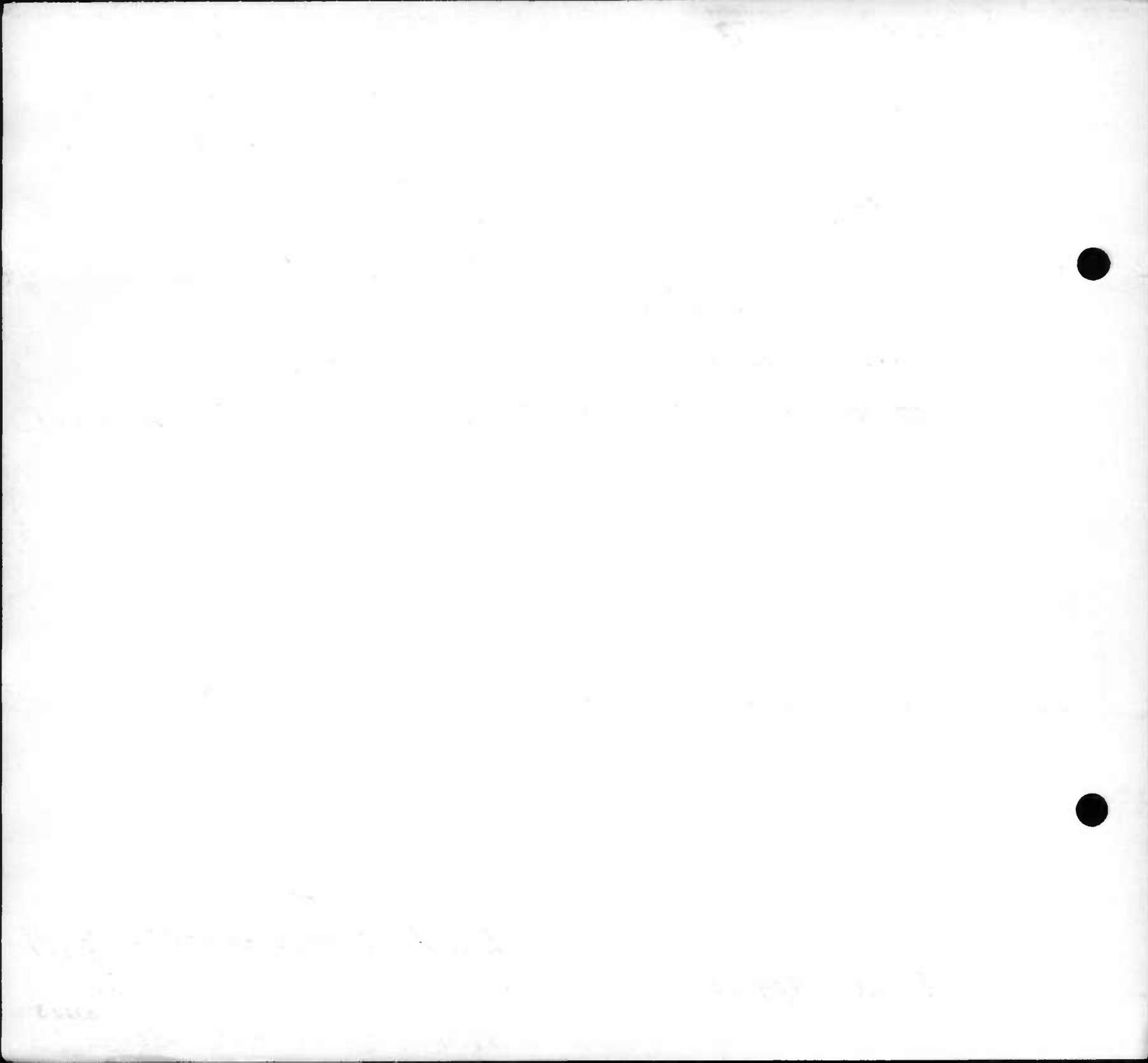
Respectfully,  
Very truly yours,

General S. M. Smith, M.D.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

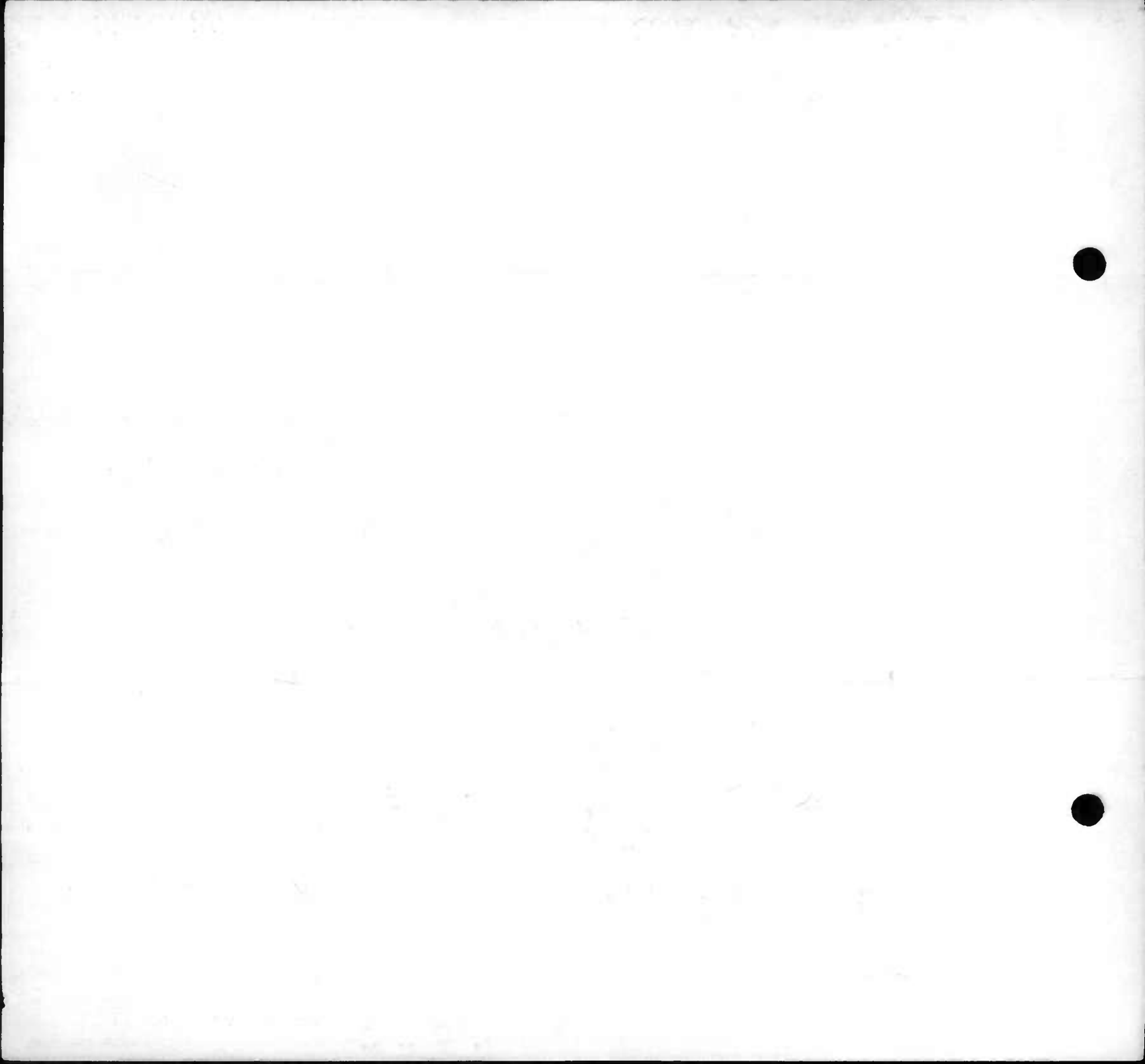
A-352		72 08025		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08025	
BIRTH NO.				STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) <u>JAKE T. ADAMS</u>				2. DATE AND HOUR OF DEATH <u>AUGUST 21, 1972</u> <u>4:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence below admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 BON SECOURS HOSPITAL</u> <u>2025 W. FAYETTE ST.</u> <u>BALTIMORE MARYLAND 21223</u>				A. STATE <u>BALTIMORE, MARYLAND</u> <u>1902</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u>			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>212 J. CAREY ST. - 31223</u>			
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-11</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSTRUCTION HELPER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Const. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jake Adams</u>				14. MOTHER'S MAIDEN NAME <u>Hora Adams</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>400-18-3015</u>		17. INFORMANT <u>Beard Adams - 212 J. Carey</u>		ADDRESS <u>10 - 21223</u>	
18. CAUSE OF DEATH <u>571.9 I</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Bleeding from Esophageal varices</u> <u>= 1 month</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Cirrhosis of liver</u> <u>years</u>			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>8/11/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding from Eso. Varices</u>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>August 2, 1972</u> to <u>August 21, 1972</u> that (I) (we) last saw the deceased alive on <u>August 21, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Chai Han</u>				23B. DATE SIGNED <u>8/21/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>CHAI HAN</u>				23D. ADDRESS <u>Bon Secours Hosp 2025 W. Fayette St. 21223</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/24/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		25B. NAME OF REGISTRAR <u>Anthony J. ...</u>		25C. FUNERAL DIRECTOR <u>John ...</u>		ADDRESS <u>901 ...</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

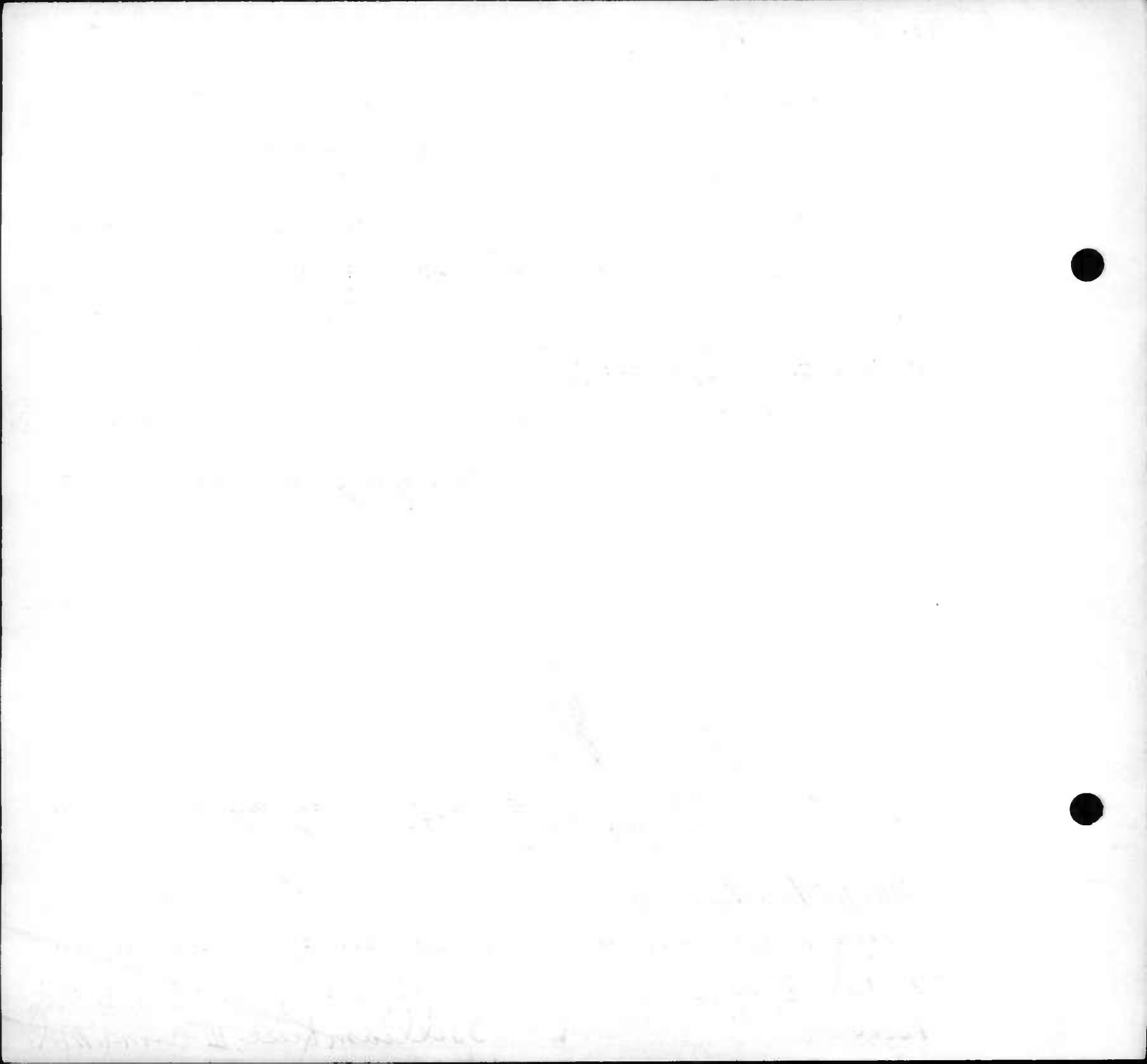
C-146		72 08026		BALTIMORE CITY HEALTH DEPARTMENT		72 08026	
CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) <i>Cavalier Joseph Ouida</i>				2. DATE AND HOUR OF DEATH <i>8-20-72 1 5<sup>50</sup> P.M.</i>			
3. PLACE IN BALTIMORE/MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>49 North Charles General Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1207</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2619 Huntington Ave.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-19-17</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal Helper</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ouida Cavalier</i>				14. MOTHER'S MAIDEN NAME <i>Elle Counabough</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes.</i>		16. SOCIAL SECURITY NO. <i>212-16-2313</i>		17. INFORMANT <i>Chart</i> ADDRESS <i>2724 N Charles St</i>			
18. <i>41241 x 2509</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cordic arrest Upper GI bleeding</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Atherosclerotic Cardiovascular Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Chronic, Diabetic Mellitus</i>							
19A. DATE OF OPERATION <i>2 none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>none</i>		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <i>(in this hospital)</i> attended the deceased from <i>Aug 15</i> 19 <i>72</i> to <i>Aug 20</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>Aug 20</i> 19 <i>72</i> and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.							
23A. SIGNATURE <i>Alan R. Taylor M.D.</i> DEGREE				23B. DATE SIGNED <i>8-20-72</i>		23C. PHYSICIAN'S NAME (Type) <i>C. P. P. P.</i> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/24/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy Balto 21225</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 23 1972</i>		25B. NAME OF REGISTRAR <i>Shirley Whorton</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Mauley 237 Patapsco Ave Balto 21225</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08027		REG. NO. 72 08027	
M-240				72 08027		STATE OF MARYLAND-DMH	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mackall - Jessie</u>				8-21-72 11:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u> <u>1400 John Street</u>				A. STATE <u>MD</u> B. COUNTY <u>Anne Arundel</u> <u>5200</u>			
				C. CITY OR TOWN <u>Severna Park</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>P.O. Box 454 - #46</u>			
5. SEX <u>m</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/23/1913</u>	9. AGE (in years last birthday) <u>58</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Samuel Mackall</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Watts</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>21-12-8669</u>		17. INFORMANT <u>Sister Mrs. Fisher</u>		ADDRESS <u>3320 Bwlt. Th St.</u>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of lung with metastasis Dec 1970</u>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from <u>February 2</u> 19 <u>72</u> to <u>August 21</u> 19 <u>72</u> that (X) (we) last saw the deceased alive on <u>August 21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Peter H. Rheinstein, MD</u>				23B. DATE SIGNED <u>21 August 1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>PETER H. RHEINSTEIN, MD</u>				23D. ADDRESS <u>621 HOLLY RIDGE RD. SEVERNA PARK, MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8/24/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Ashbury Down Neck</u>		24D. LOCATION (City, town, or county) (State) <u>Severna Park, A.A. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. Heston</u>		25C. FUNERAL DIRECTOR <u>William Reese, II</u>		ADDRESS <u>Severna Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-008		72 08028		BALTIMORE CITY HEALTH DEPT.		Registered No. 72 08028	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ROSE MAY				August 21, 1972 13.30 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION EDGEWOOD NURSING HOME				A. STATE B. COUNTY C. CITY OR TOWN D. STREET ADDRESS			
(If not in hospital or institution, give street address or location)				MARYLAND D. C. BALTIMORE Washington EDGEWOOD NURSING HOME 4501 Connecticut Ave. N.W.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	WIDOWED	July 10, 1889	83	HOUSEWIFE	NEW YORK, NEW YORK	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
HOUSEWIFE		AT HOME	NEW YORK, NEW YORK		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
SIMON SCHWARTZ				ESTHER BAUMOHL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS		
NO		219-32-3328	BERNARD DANZANSKY & SON,		3501 - 14th STREET, N.W. WASHINGTON, D.C. 20010		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				1 hr			
ANTECEDENT CAUSES				yours			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1965 to August 21, 1972, that (I) (we) last saw the deceased alive on August 5, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
X Newland E. Day MD							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
NEWLAND E. DAY				4-2-3345 St Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
REMOVAL-BURIAL		8/23/72		WASHINGTON HEBREW		WASHINGTON, D. C.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 23 1972		Sidney J. Gordon		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	



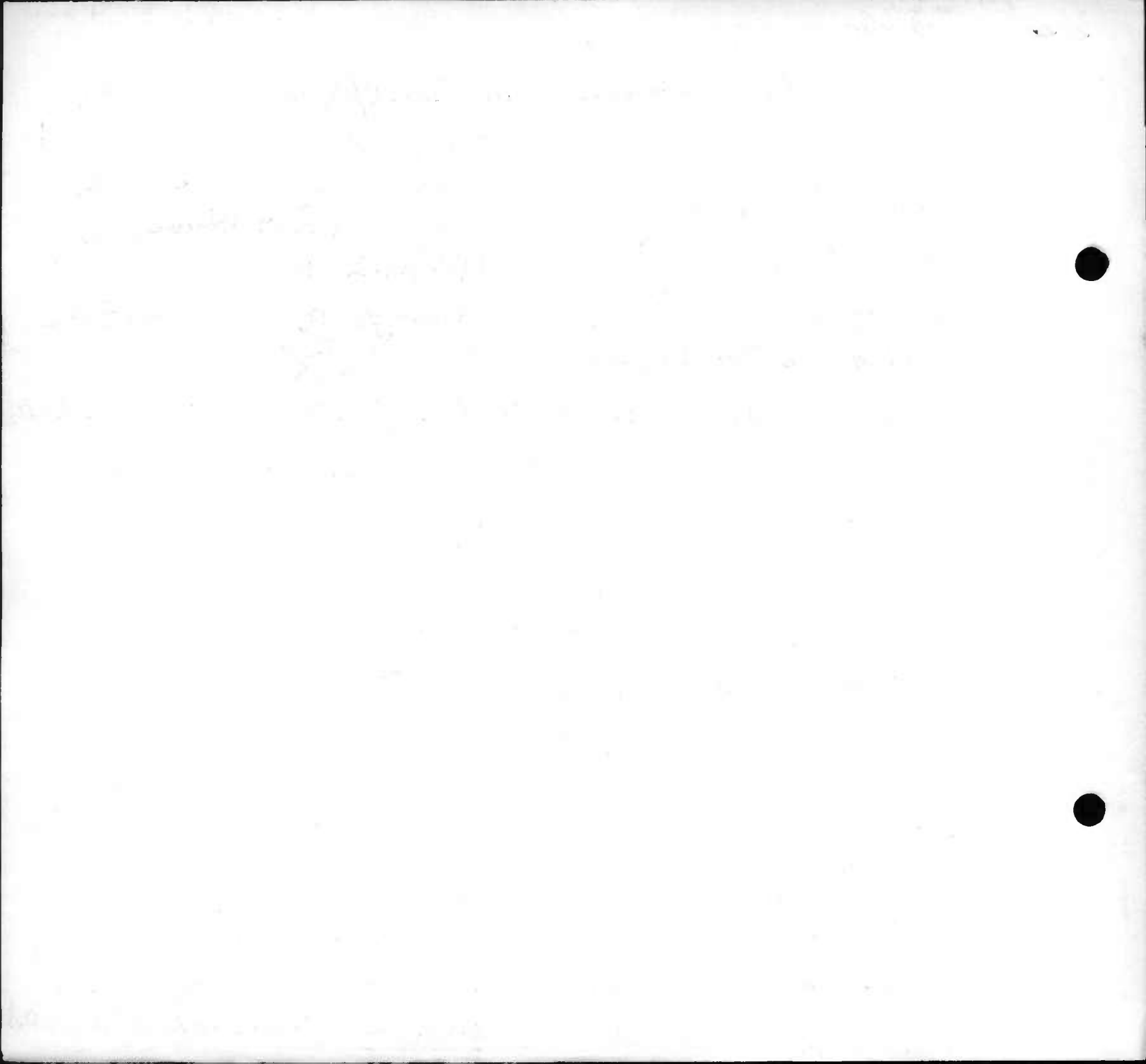
6000 Bellvue Ave

9/29/72 - Letter from Seymour, S. Mintz, Esquire and Individual Income Tax Return,  
District of Columbia. Year 1971.

FUNERAL DIRECTOR: IMPORTANT

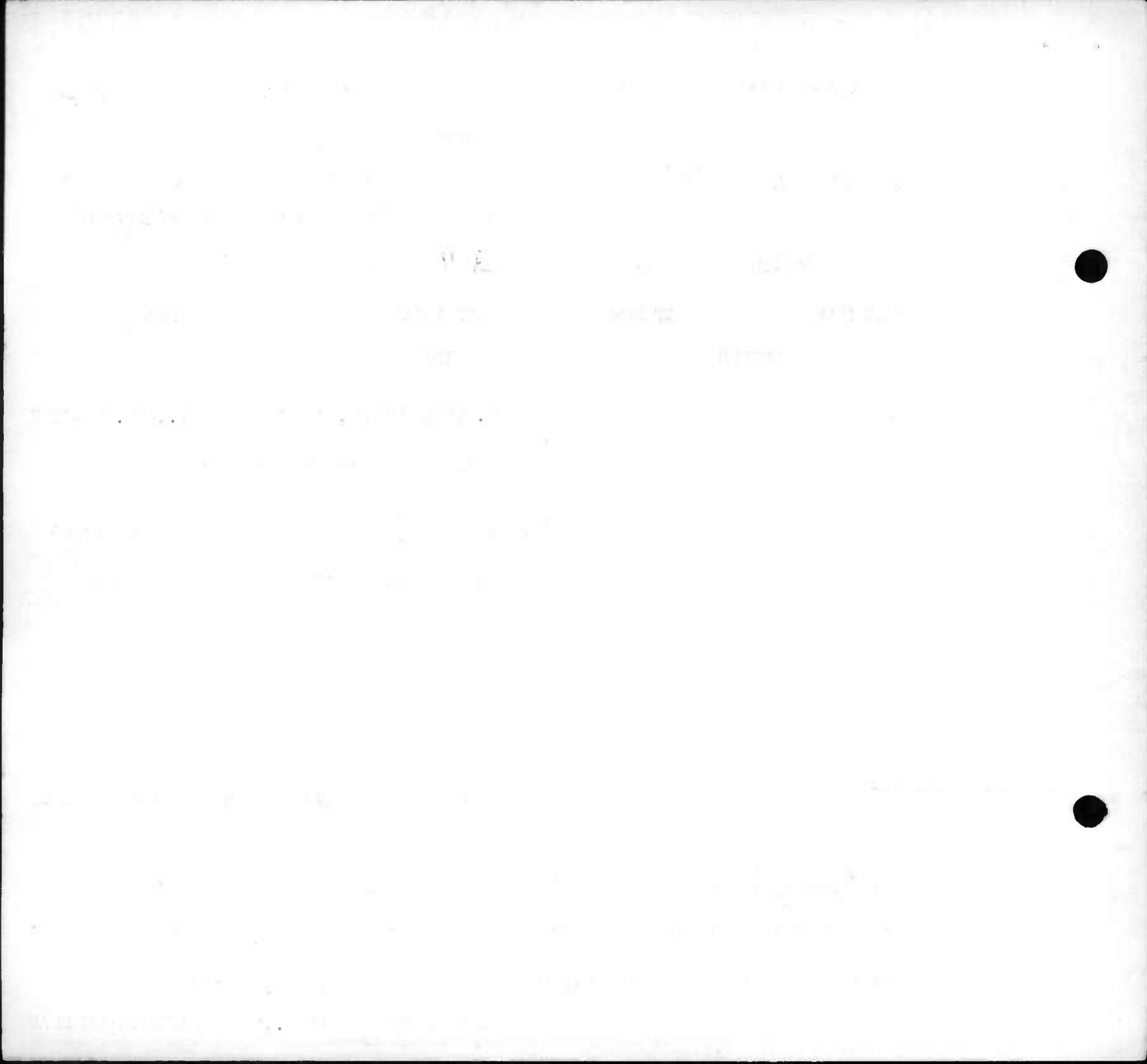
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 08029 CERTIFICATE OF DEATH				REG. NO. 72 08029	
BIRTH NO. M-242		STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) DR. ALFRED MICHELSON		2. DATE AND HOUR OF DEATH 8/19/72 1:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL of BALTO, Inc		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3203 Old Post Drive			
5. SEX MALE	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/16/1912	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Psychiatrist		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Morris Michelson		14. MOTHER'S MAIDEN NAME Jennie Lien	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 065-38-4232		17. INFORMANT Mrs Sylvia Michelson ADDRESS 3502 Old Post Dr	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Symptothetomy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs ? 10 hrs.					
19A. DATE OF OPERATION 8/18/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED occlusion artery CLE		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) this hospital attended the deceased from 8/18 1972 to 8/19 1972 that (2) we lost saw the deceased alive on 8/19 1972 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Michael Levin, MD		23B. DATE SIGNED 8/19/72		23C. PHYSICIAN'S NAME (Type) Michael L. Levin	
23D. ADDRESS 222 W. Cold Spring Lane 'Back'		24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Removal 8/20/72			
24B. DATE 8/20/72		24C. NAME OF CEMETERY or CREMATORY Beth David		24D. LOCATION Elmont L.I. New York	
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1972		25B. NAME OF REGISTRAR Sydney Johnston		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros 6010 Reisterstown Rd	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08030		72 08030	
BIRTH NO.		K-145		72 08030	
1. NAME OF DECEASED (Type or Print)		KAPLAN Celia		REG. NO.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		STATE OF MARYLAND - DIME	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD		B. COUNTY BALTIMORE	
SINAI Hospital.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
42		E. STREET AND NUMBER 2500 W. Belvedere Ave. #21215		2717	
5. SEX Female		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2/10/1894	
HOUSEWIFE		AT HOME		9. AGE (In years last birthday) 78 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
13. FATHER'S NAME HURDES		14. MOTHER'S MAIDEN NAME IDA		11. BIRTHPLACE (State or foreign country) NEW YORK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? USA	
18. 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESPIRATORY Arrest Acute M.I. (B) DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30' 2 days 60'	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/10/72 to 8/18/72 that (I) (we) last saw the deceased alive on 8/18/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michaelides		23B. DATE SIGNED 8/18/72		23C. PHYSICIAN'S NAME (Type) K. MICHAELIDES	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/20/72		24C. NAME OF CEMETERY or CREMATORY SHAAREI TFILOH	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE RECEIVED BY HEALTH DEPT. AUG 23 1972		24F. NAME OF REGISTRAR L. J. H. H. H.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 23 1972		25B. NAME OF REGISTRAR L. J. H. H. H.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08031		72 08031	
BIRTH NO. <u>E-524</u>		72 08031		REG. NO. <u>72 08031</u>	
1. NAME OF DECEASED (Type or Print) <u>Anna Engel</u>		2. DATE AND HOUR OF DEATH <u>8/18/72</u> <u>3:50</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u>		C. CITY OR TOWN <u>RANDALSTOWN</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>9014 SAMOSET ROAD</u>			
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/5/98</u>		9. AGE (in years last birthday) <u>74</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MORRIS GOLDBERG</u>	
14. MOTHER'S MAIDEN NAME <u>NAOMI ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. EDITH GOLDMAN, 3805 JANBROOK RD. #21133</u>		ADDRESS			
18. <u>4/2/51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HT FAILURE</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ATHEROSCLEROTIC HEART DISEASE</u>			
19. DATE OF OPERATION <u>0</u>		20. AUTOPSY? (Yes or No) <u>NO</u>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/14</u> 19 <u>72</u> to <u>8/18</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <u>Karen H. Lichtenfeld MD</u>			
24. DATE <u>8/20/72</u>		25. NAME OF REGISTRAR <u>SOL LEVINSON &amp; BROS.</u>		26. ADDRESS <u>6010 REISTERSTOWN ROAD</u>	
27. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		28. NAME OF REGISTRAR <u>SOL LEVINSON &amp; BROS.</u>			
29. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		30. NAME OF REGISTRAR <u>SOL LEVINSON &amp; BROS.</u>			

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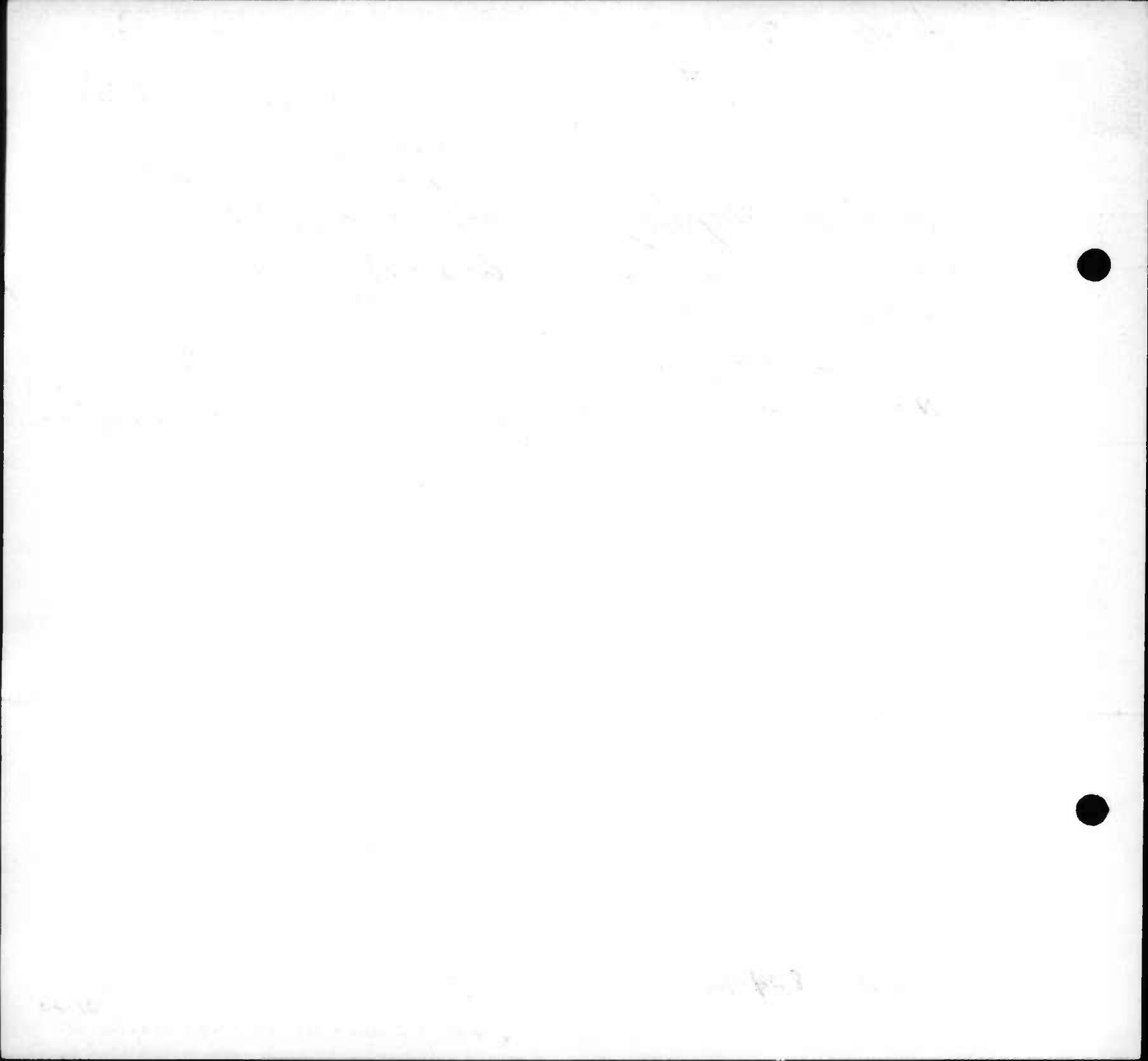
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 08032</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 08032</span> STATE OF MARYLAND-DUMF	
1. NAME OF DECEASED (Type or Print) <i>Catherine Hausley</i>		2. DATE AND HOUR OF DEATH <i>8-21-72</i> <i>8:25 AM</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2834</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>4918 Linbury Rd. - 21229</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-5-98</i>	9. AGE (in years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Balt. Md.</i>	
13. FATHER'S NAME <i>George Higgins</i>		14. MOTHER'S MAIDEN NAME <i>Emma Reinhardt</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John B. Hausley - 4918 Linbury Rd.</i>	
18. <i>41019 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-16-1972</i> to <i>8-21-1972</i> that (I) (we) last saw the deceased alive on <i>8-21-1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. H. Siddiqui</i>		M.D. DEGREE <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>8-21-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. H. Siddiqui</i>		23D. ADDRESS <i>Lutheran Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>buried</i>		24B. DATE <i>8/24/72</i>		24C. NAME of CEMETERY or CREMATORY <i>St. James Cemetery</i>	
24D. LOCATION <i>St. James Md.</i>		24E. CITY, town, or county <i>Balt. Md.</i>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 23 1972</i>		25B. NAME OF REGISTRAR <i>L. J. Johnson</i>		25C. FUNERAL DIRECTOR <i>John J. ...</i>	
25D. ADDRESS <i>...</i>		25E. ADDRESS <i>...</i>			



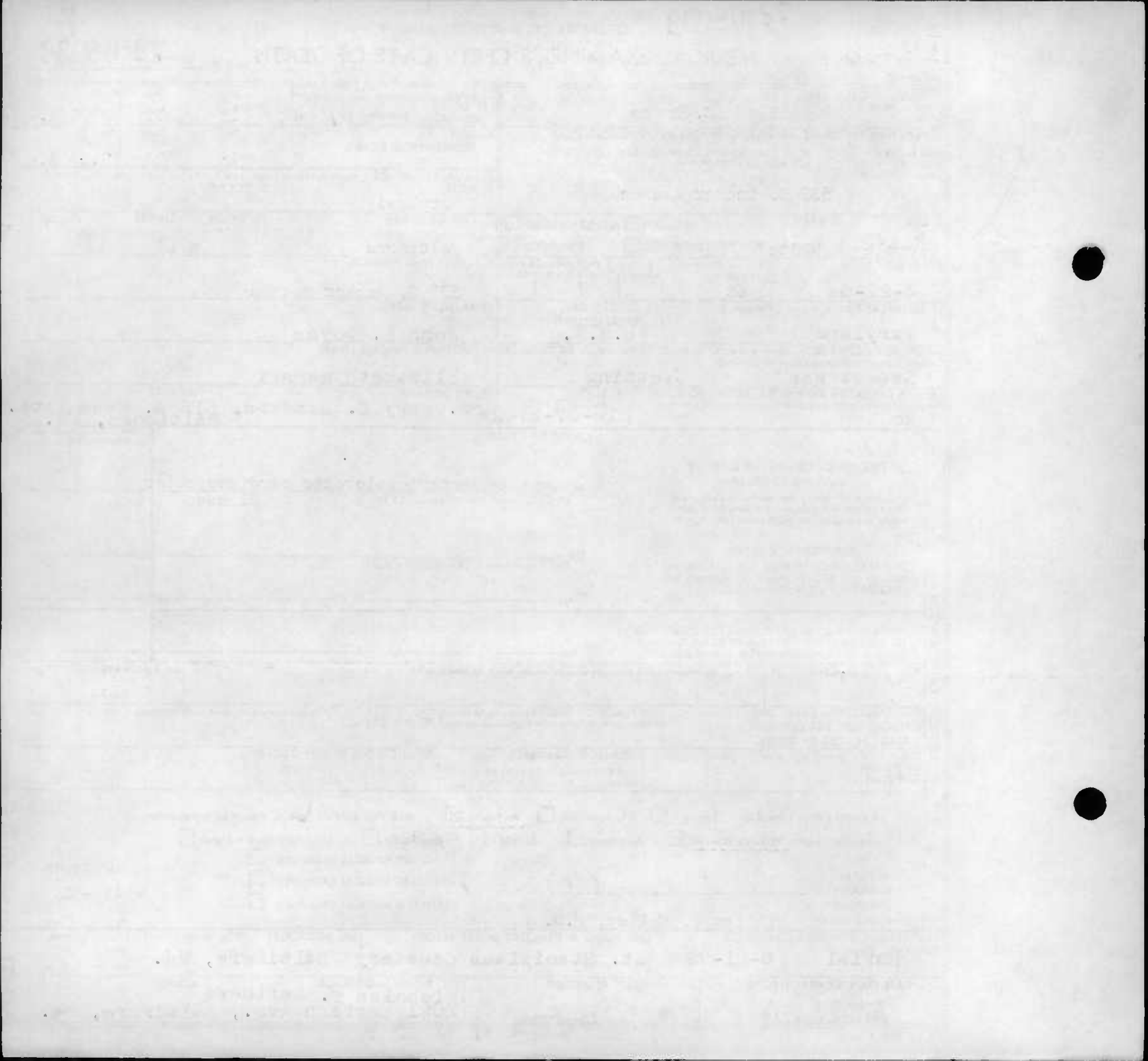
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08033

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lillian C. Doyas		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 18 72 9:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 533 S. Decker Avenue		3. DATE PRONOUNCED DEAD Month Day Year 8 18 72 9:30 A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 102			
6. SEX Female	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 3-22-04		10. AGE (In years last birthday) 68	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 533 S. Decker Avenue
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		14B. KIND OF BUSINESS OR INDUSTRY Clothing	13. FATHER'S NAME John L. Doyas
15. MOTHER'S MAIDEN NAME Elizabeth Marski			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-07-2742A	18. INFORMANT Mrs. Mary S. Sanders, 515 S. Decker Ave., Baltimore, Md.
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2-2-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>W.P. Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. DATE SIGNED 8-18-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-21-72	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1972		25B. NAME OF REGISTRAR <i>William P. Mulloy</i>	
25C. FUNERAL DIRECTOR Nicholas T. Matthews 3021 Eastern Ave., Baltimore, Md.		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08034</b>	
P-500 <b>72 08034</b>		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>Erma M. Payne</b>		2. DATE AND HOUR OF DEATH <b>8/20/72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Balto Gen Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> COUNTY <b>AA</b> C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>316 14th Ave 21225</b>	
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1890</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	9. AGE (In years last birthday) <b>82</b>
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Rouse</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212 74 5153</b>	
17. INFORMANT <b>Erma Rainey</b>		ADDRESS <b>316 14th Ave Balto Md. 21225</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b> (B) <b>Severe Atherosclerotic Cardio</b> (C) <b>Vascular Disease</b>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1965</b> to <b>August 19 1972</b> , that (I) (we) last saw the deceased alive on <b>August 3 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Mario J. Reda MD</b>		23B. DATE SIGNED <b>8/22/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARIO J. REDA MD</b>		23D. ADDRESS <b>4016 Ritchie Hwy Balto Md. 21208</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/23/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Wash Blvd Dorsey Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Andrew H. Hinton</b>	
25C. FUNERAL DIRECTOR <b>Mouffly Funeral Home</b>		ADDRESS <b>237 Patapsco Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>W-420</b>		72 08035		CERTIFICATE OF DEATH		REG. NO. <b>72 08035</b>	
1. NAME OF DECEASED (Type or Print) <b>WELLS, LEOTA G.</b>				2. DATE AND HOUR OF DEATH <b>8/18/72 11:05 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED OEO				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> Balto. <b>AA 5200</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> <b>33RD &amp; CALVERT ST. BALTIMORE 21218</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>GLEN BURNIE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-11-1913</b>	
9. AGE (In years last birthday) <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LP Nurse</b>		11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>WILLIAM GORDON</b>				14. MOTHER'S MAIDEN NAME <b>BROWN, ADA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>372-07-7691</b>		17. INFORMANT <b>Elmer M. Wells, Sams as Above</b>		18. CAUSE OF DEATH <b>metastatic carcinoma</b> <b>carcinoma colon</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>4 hrs</b>			
19A. DATE OF OPERATION <b>8/18/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>U</b> (this hospital) attended the deceased from <b>8-14</b> 19 <b>72</b> to <b>8-18</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>7:30 PM 8/18</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Murari Lal Bispura M.B.B.S.</b>				23B. DATE SIGNED <b>8/18/72</b>		23C. PHYSICIAN'S NAME (Type) <b>MURARI LAL BISPUA</b> <b>M.B.B.S.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Hinton</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto., Md.</b>		ADDRESS	



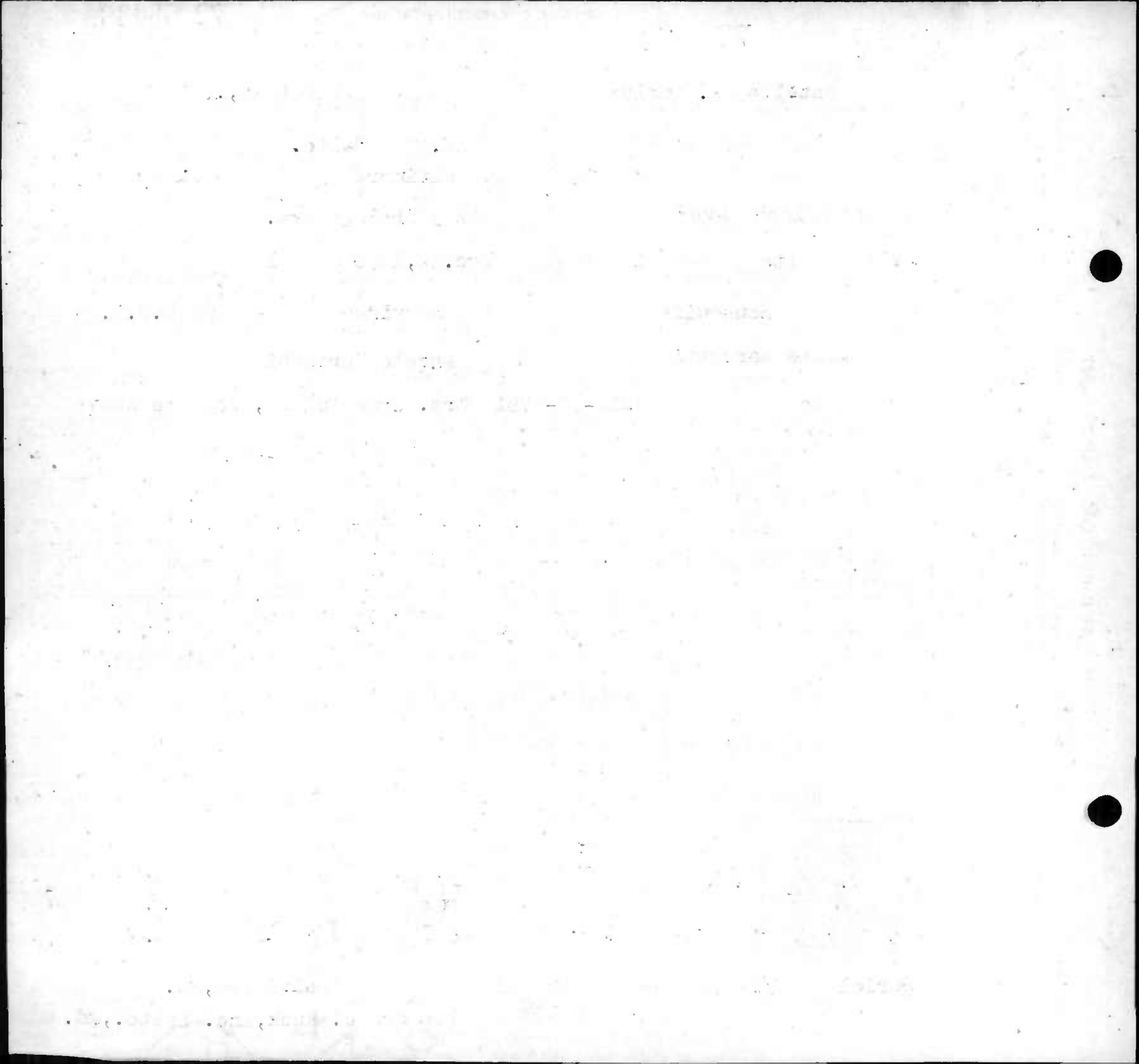




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08036	
72 08036				STATE OF MARYLAND-DEMH	
BIRTH NO. K-420				1. NAME OF DECEASED (Type or Print) <b>Estelle A. Kalus</b>	
2. DATE AND HOUR OF DEATH <b>August 19, 1972</b>				M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b>		
<b>00</b>			C. CITY OR TOWN <b>Baltimore</b>		
<b>4203 Sheldon Ave</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			E. STREET AND NUMBER <b>4203 Sheldon Ave.</b>		
8. DATE OF BIRTH <b>Dec. 12, 1890</b> 9. AGE (in years last birthday) <b>81</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Barsotti</b>			14. MOTHER'S MAIDEN NAME <b>Angela Fureschi</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-56-9791</b>		
17. INFORMANT <b>Mrs. Irma Mullin, Same as Above</b>			ADDRESS		
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>Coronary Heart Failure 7 days</b>		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			<b>Hypertensive Cardiovascular Disease 20 years</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF:			<b>30 years</b>		
(C)					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 47</b> to <b>August 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Melvin F. Polek</b>			23B. DATE SIGNED <b>August 21, 1972</b>		
23C. PHYSICIAN'S NAME (Type) <b>MELVIN F. POLEK</b>			23D. ADDRESS <b>3603 BELAIR ROAD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE <b>8/22/72</b>		
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>			25B. NAME OF REGISTRAR <b>Leonard J. Ruck, Inc. Balto., Md.</b>		
25C. FUNERAL DIRECTOR			ADDRESS		



1

K-640

72 08037

STATE OF MARYLAND-DEPT  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08037

1. NAME OF DECEASED (Type or Print) <b>George T. Kruelle</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 20 72 3:40 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>2803 Hamilton Avenue</b> (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 20 72 3:40 p.m.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2706</b>			
6. SEX <b>male</b>	7. RACE <b>white</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>May 31, 1906</b>		10. AGE (In years last birthday) <b>66</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sun Carrier</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>213-10-6885</b>	
18. INFORMANT <b>Mrs Rosella M Kruelle</b>		ADDRESS <b>Same</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardio-vascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/24/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Immanuel</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J Ruck Inc. Baltimore, Md</b>	
25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>		ADDRESS	

10-10-68

U.S. AIR FORCE

OFFICE OF THE

ATTORNEY GENERAL

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

10-10-68

10-10-68

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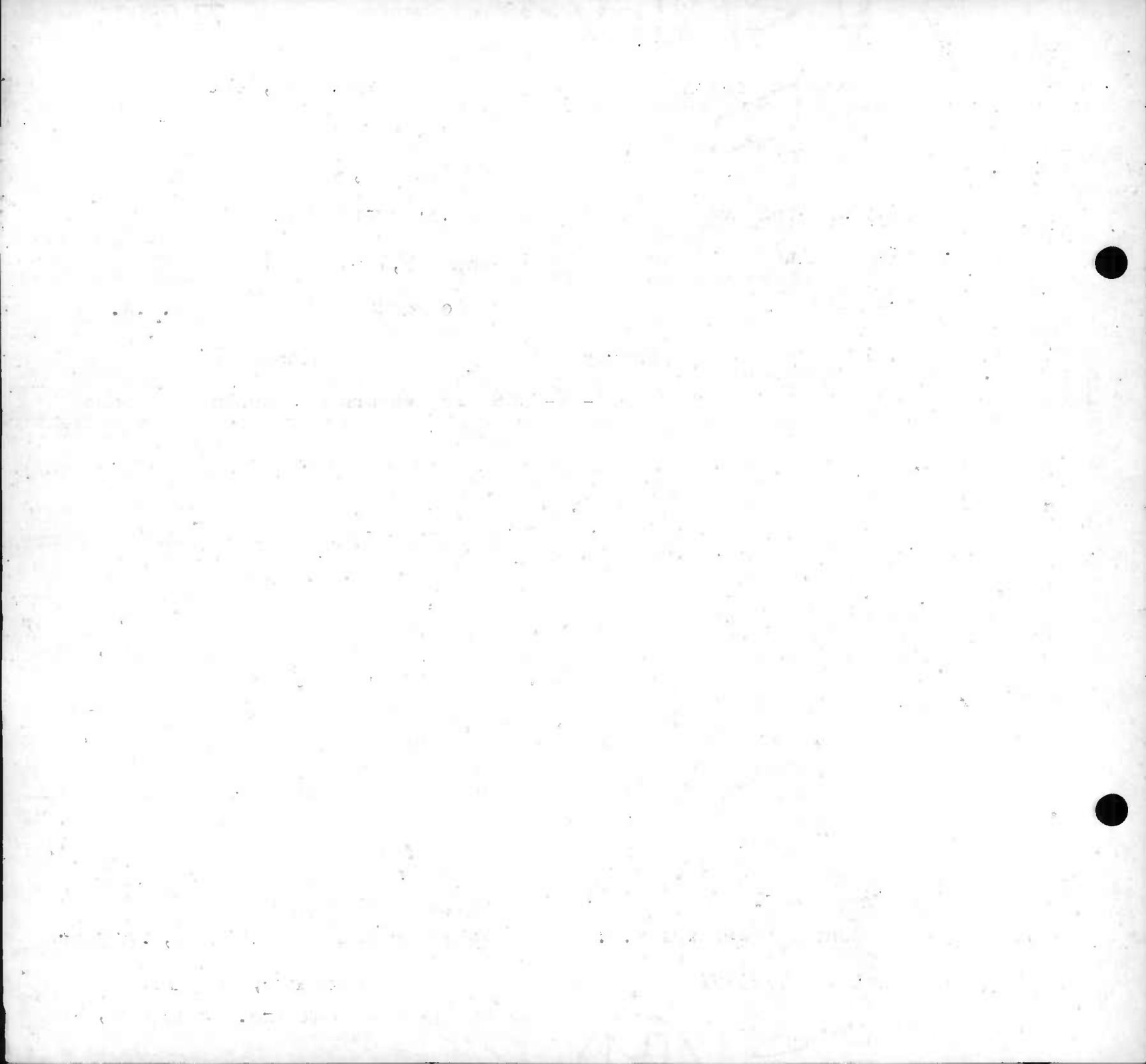
U.S. AIR FORCE

U.S. AIR FORCE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>72 08038</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 08038</u>	
1. NAME OF DECEASED (Type or Print) <u>Anna M Hasson</u>				2. DATE AND HOUR OF DEATH <u>August 20, 1972</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00</u> <u>3015 Royston Ave</u>				4. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2745</u> C. CITY OR TOWN <u>Baltimore,</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3015 Royston Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1891</u>		9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>?</u> <u>Landrey</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>506-09-3568</u>		17. INFORMANT <u>Mr Leonard J Agnello</u>		ADDRESS <u>Same</u>
18. <u>244X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary artery dis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypothyroidism</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>20 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19 50</u> to <u>Aug 20</u> 19 <u>72</u> , that (I) <del>was</del> last saw the deceased alive on <u>August 6,</u> 19 <u>72</u> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> <del>not</del> view the body after death.							
23A. SIGNATURE <u>Donald R Jandorf</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>8-21-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Donald R Jandorf M.D.</u>				23D. ADDRESS <u>7403 Harford Rd Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/23/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		25B. NAME OF REGISTRAR <u>Sidney W. Horton</u>		25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. Baltimore, Md</u>		ADDRESS	



E-645

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

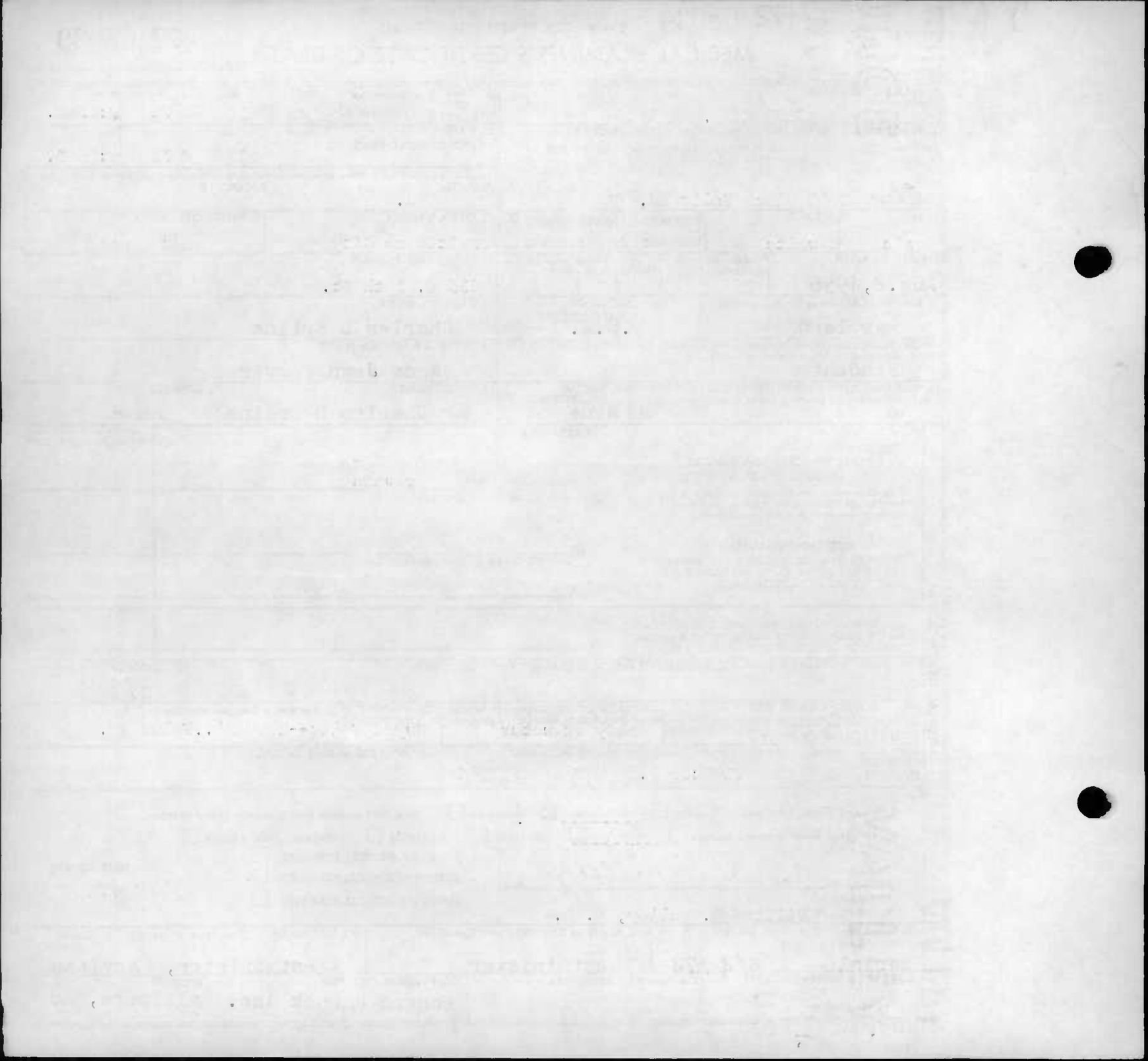
72 08039

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>GREGORY L. ERLINE</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 18 72 9:55 P. M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2900 Block Falls Rd.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 18 72 9:55 P. M.</b>			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>904</b>				C. CITY OR TOWN <b>Baltimore City</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>male</b>	7. RACE <b>white</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>635 E. 30th St.</b>			
9. DATE OF BIRTH <b>Aug. 8, 1956</b>		10. AGE (In years lost birthday) <b>16</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles L Erline</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME <b>Anna Jean Farver</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
17. SOCIAL SECURITY NO. <b>None</b>				18. INFORMANT ADDRESS <b>Mr Charles L Erline Same</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E910.91</b> Drowning (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>8/22/72</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>No</b>				22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <b>1305</b>			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>body of water</b>				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Gwynn Falls--2900 Bl.. Falls Rd.</b>			
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>8 18 72 9:55 P.</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23.			
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W P Mulloy</b> EXAMINER'S NAME (Type) <b>William P. Mulloy, M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/19/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/22/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Westminister</b>		24D. LOCATION (City, town, or county) (State) <b>Westminister, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>W P Mulloy</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc. Baltimore, Md</b>			



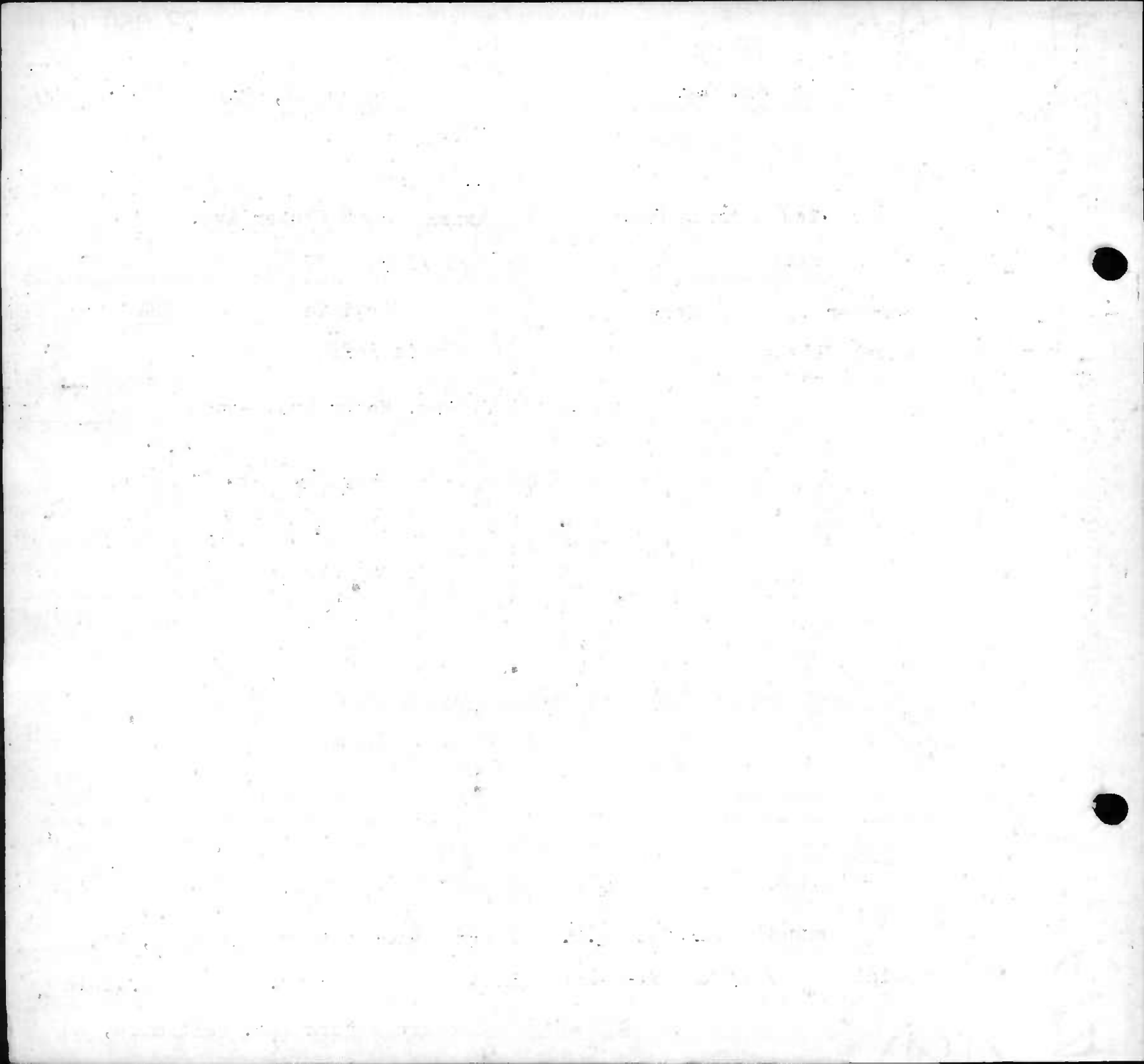




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08010	
C-200 72 08010				STATE OF MARYLAND-DEHM	
BIRTH NO.				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <b>Susie Jane Cox</b>				2. DATE AND HOUR OF DEATH <b>August 21, 1972 2:15 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Harbor View Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2631</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Harbor 6008 Plumer Ave.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/17/1894</b>		9. AGE (In years lost birthday) <b>77</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Samuel Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Poff</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 54 6698J1</b>		17. INFORMANT ADDRESS <b>Mrs. Henry Bresh-Same</b>	
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Standstill</b> II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Crippling Rheumatoid arthritis Gen'l</b> <b>Malnutrition</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>6/24</b> 19 <b>70</b> to <b>8/19</b> 19 <b>72</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>8/19</b> 19 <b>72</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <b>Kenneth Krulevitz MD</b>				23B. DATE SIGNED <b>8/21/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Kenneth Krulevitz M.D.</b>				23D. ADDRESS <b>115 W Monument St Baltimore, Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/25/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill</b>	
24D. LOCATION <b>Floyd Co.</b>		24E. LOCATION (City, town, or county) (State) <b>Virginia</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Lidney H. Wooten</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc. Baltimore, Md</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R-100</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 080411</b>	
1. NAME OF DECEASED (Type or Print) <b>LEO C. RUPP</b>		2. DATE AND HOUR OF DEATH <b>8-20-72 1:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITAL</b> <b>4940 Eastern Ave. Baltimore, Md. 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2611</b> C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>603 S. BOULDIN ST. 007</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-18-29</b>	9. AGE (In years last birthday) <b>43</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICIAN</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWARD A. RUPP</b>			
14. MOTHER'S MAIDEN NAME <b>DOROTHY M. PUDNEY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1947-1950</b>			
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>DOROTHY M. RUPP, 603 S. BOULDIN ST.</b>			
18. <b>573.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH S.S. 26-24-3493</b> <b>CARDIORESPIRATORY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC HEPATIC FAILURE 10 YRS.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>HEPATORENAL SYNDROME</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS.</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>—</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NO</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>7-12</b> 19 <b>72</b> to <b>8-20</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>7-20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frank Meronk, M.D.</b>		23B. DATE SIGNED <b>8-20-72</b>		23C. PHYSICIAN'S NAME (Type) <b>FRANK MERONK, M.D.</b>	
23D. ADDRESS <b>4940 Eastern Ave/Baltimore, Md. 21224</b>		23E. FUNERAL DIRECTOR <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-23-72</b>		24C. NAME of CEMETERY or CREMATORY <b>SACRED HEART CEM.</b>	
24D. LOCATION (City, town, or county) <b>7401 GERMAN HILL RD, BA. CO., MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>			
25B. NAME OF REGISTRAR <b>Adrian [Signature]</b>		25C. FUNERAL DIRECTOR <b>Charles [Signature]</b>			

15-11-11  
10-11-11

PERMANENT

1-18-11

EDWARD A. RUPP

EDWARD A. RUPP

EDWARD A. RUPP

1-18-11

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1-18-11

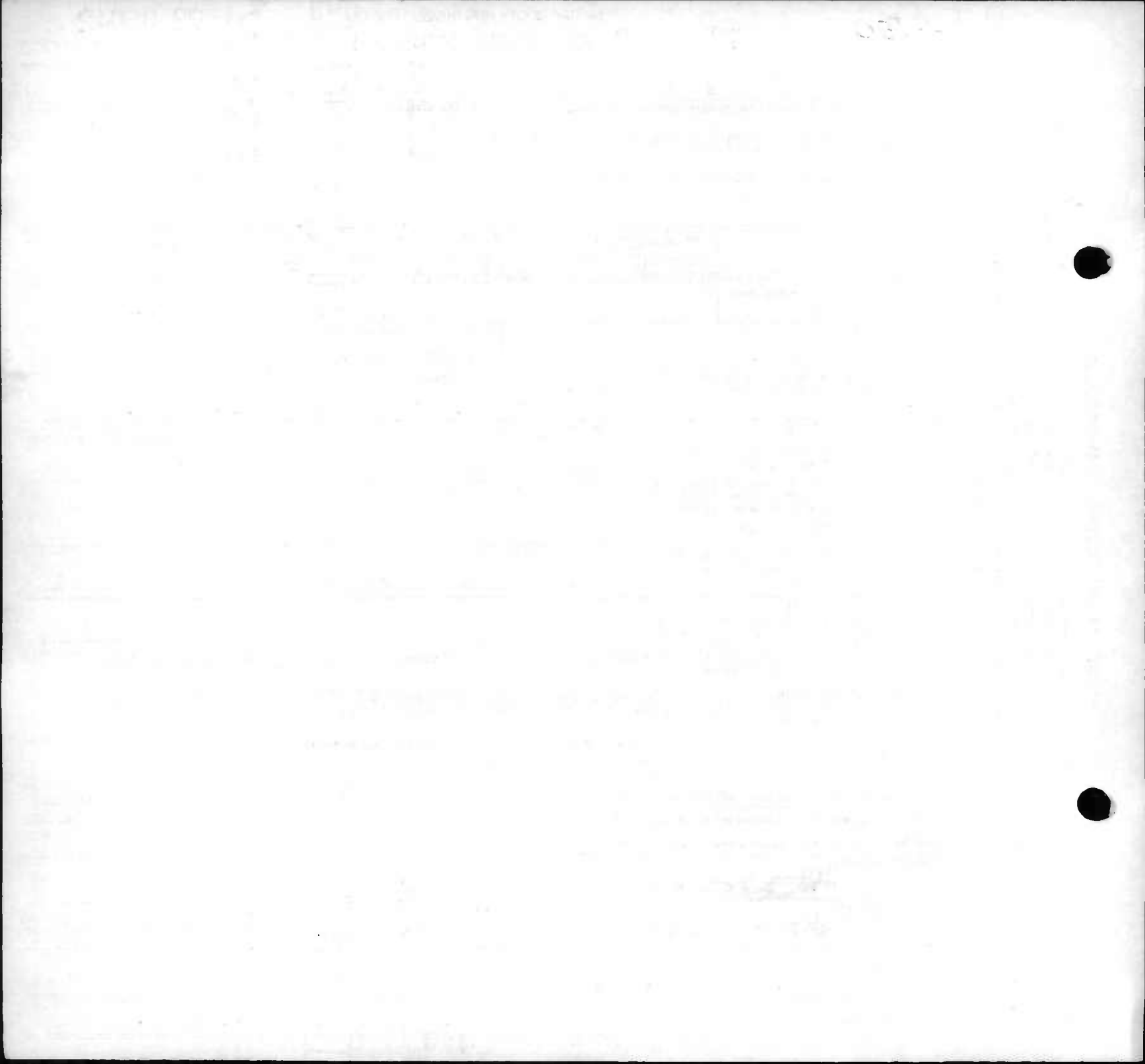
1-18-11

1-18-11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>H-650</span> <span>72 08042</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>72 08042</span> </div> <div style="text-align: right;">STATE OF MARYLAND-DMH</div>	
1. NAME OF DECEASED (Type or Print) <b>WILLIAM HEARN</b>		2. DATE AND HOUR OF DEATH <b>8/22/72 3AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION: <b>THE UNION MEMORIAL HOSP.</b> <b>44</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE: <b>Maryland</b> B. COUNTY: <b>2037</b> C. CITY OR TOWN: <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: <b>407 Mt. Holly St.</b>	
5. SEX: <b>M</b>	6. RACE: <b>B.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <b>01/01/1910</b> 9. AGE (In years last birthday): <b>62</b> 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Cab driver</b>		11. BIRTHPLACE (State or foreign country): <b>Baltimore, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>William Hearn Sr.</b>		14. MOTHER'S MAIDEN NAME: <b>Frances Sowley</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service: <b>No</b>		16. SOCIAL SECURITY NO.: <b>218-09-9711</b>	
		17. INFORMANT: <b>Mrs. Sallie Hearn 407 Mt. Holly St.</b> ADDRESS:	
18. <b>185X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>ELECTROLYTIC IMBALANCE</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CHRONIC RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ADENOCARCINOMA PROSTATE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION: <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indefinitely medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>08/08</b> 19 <b>72</b> to <b>08/22</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>08/22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE: <b>[Signature]</b>		23B. DATE SIGNED: <b>08/22/72</b>	
23C. PHYSICIAN'S NAME (Type): <b>[Signature]</b>		23D. ADDRESS: <b>H.D. UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify): <b>Burial</b>		24B. DATE: <b>8/24/72</b>	
24C. NAME OF CEMETERY OR CREMATORY: <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State): <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.: <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR: <b>[Signature]</b>	
25C. FUNERAL DIRECTOR: <b>Mrs. Mary E. Law 802 Madison Ave.</b>		ADDRESS:	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-232		BALTIMORE CITY HEALTH DEPARTMENT		72 08043		72 08043	
BIRTH NO.		72 08043		CERTIFICATE OF DEATH		REQ. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)	
GEORGE JUSTICE		8/15/72 11:40 P.M.		2403		Maryland	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Kentucky		USA		UNKNOWN		UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
UNKNOWN		208-01-600		William J. Justice		1179 Victory Blvd N.Y.	
18. CAUSE OF DEATH		19. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
481X1		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		NO		NO	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Right lower lobe pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(B) CHRONIC LUNG DISEASE		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 12 1972 to August 15 1972		23A. SIGNATURE		23B. DATE SIGNED			
that (I) (we) lost saw the deceased alive on August 15 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		Virginia Garza-Mercado		8-15-72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL - CREMATION, REMOVAL (Specify)		24B. DATE	
VIRGINIA F. MERCADO, M.D.		Providence Hospital		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
AUG 23 1972		Sidney [Signature]		RAYMOND J. CURRAN		817 SCARLETT DR. TOWSON, MD. 21204	

10/3/67

1001 Light St.

OT



E-363

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08044

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Milton Edwards</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>7 25 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>7 25 72 10:45 a.m.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>UNKNOWN</b>		10. AGE (In years last birthday) <b>74</b>	
11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		17. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
18. INFORMANT <b>CHURCH HOME</b>		ADDRESS <b>BALTO, MD.</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL (CREMATION, REMOVAL) (Specify)		24B. DATE <b>8-21-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>U of M. Anatomy Bldg</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO, MD</b>	
25A. DATE REC'D BY HEALTH DEPT <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Raymond L. Curran</b>	
25C. FUNERAL DIRECTOR <b>817 Scoble H. St.</b>		ADDRESS <b>BALTIMORE, MD 21204</b>	

11-30-11

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">S-363</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>72 08045</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">72 08045</span> STATE OF MARYLAND-DHMH	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LOUISA STEWART</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">8/21/72 5:10 P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">BON SECOURS HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">BALTO.</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTO.</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">610 N. MONROE ST. MD 21217</span>	
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/14/93</span>
9. AGE (In years last birthday) <span style="font-size: 1.2em;">78</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">COOK</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MD</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Pvt. HOMES</span>	12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">PETER MITCHELL</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ANNIE KEWL</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">219-30-1821</span>	17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. Beatrice Stokes 1223 Valley Street</span>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">SICK SINUS SYNDROME</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Years</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">18/21/72</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">SICK SINUS SYNDROME</span>	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">8/9</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">8/21</span> 19 <span style="font-size: 1.2em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">8/21</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Chaihan</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">8/21/72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CHAIHAN</span>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">8-25-72</span>	
24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Brooks United Methodist Church Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Calvert Co. Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">AUG 23 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">S. J. G. G. G.</span>	
25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">NUTTER FUNERAL HOME 3035 W. NORTH AVE.</span>			

9/20/72 A Cardiac Arrhythmia

B. Atherosclerotic Ht. Dis

Letter from Bow Secours Hospital  
filed in Bur of Biostat - American Bldy  
92

COOK

W.S. HAWES

CM

ACU

WED

15/14/12

88

WED

15/14/12

88

WED

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WED

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15/14/12

88

WED

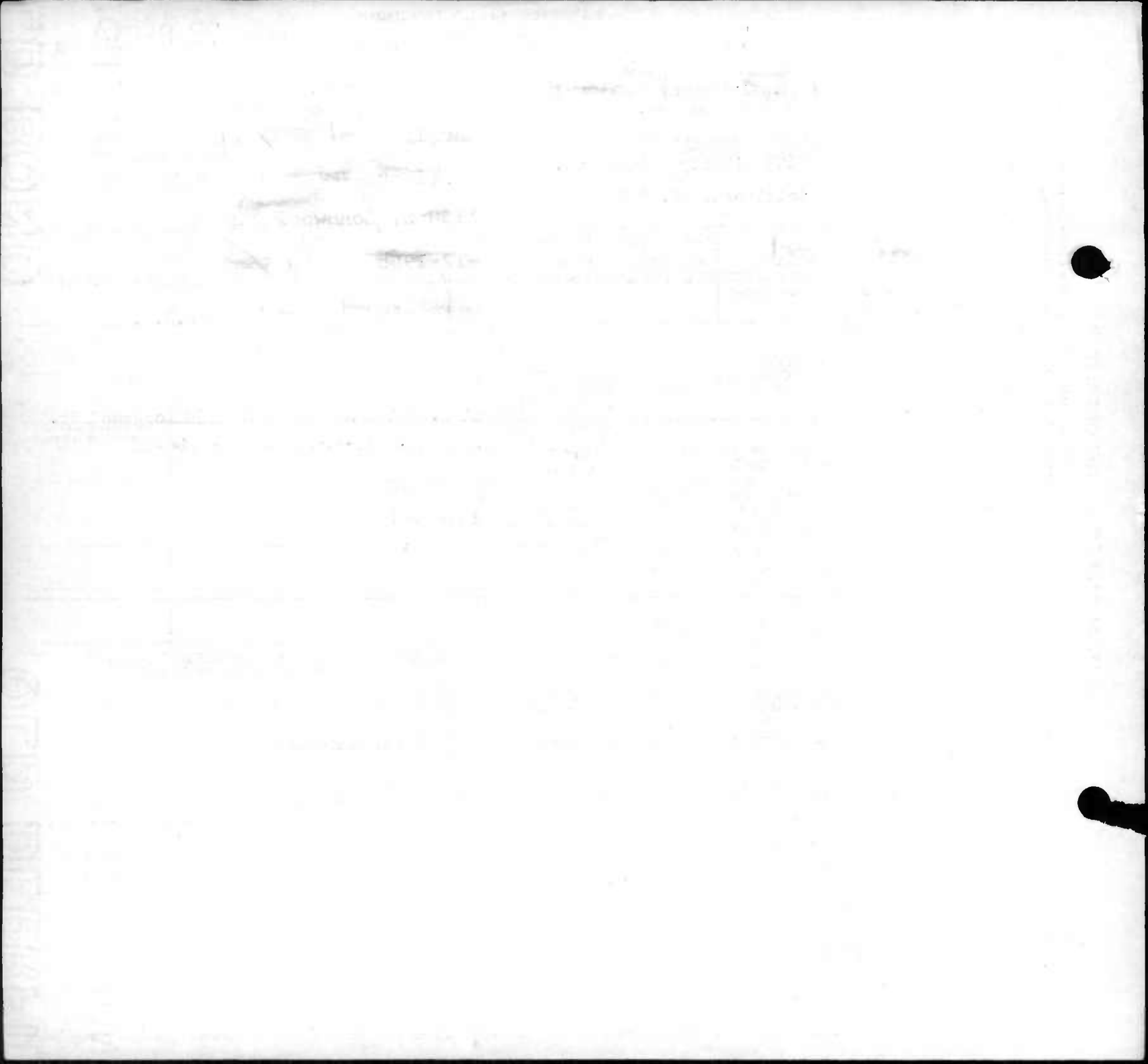
15/14/12

88

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08016</u>	
C-455 72 08016				CERTIFICATE OF DEATH	
BIRTH NO. <u>C-455</u>		1. NAME OF DECEASED (Type or Print) <u>Sadie M. Coleman</u>		2. DATE AND HOUR OF DEATH <u>Aug. 21, 1972</u> <u>12 30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39 Provident Hosp.</u> <u>Baltimore, Md. 21215</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1607</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1158 N. Longwood Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-1905</u>		9. AGE (In years, last birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>George Howard</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-22-1700</u>		17. INFORMANT <u>Paul D. Coleman (HUSBAND)</u>
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Hypertensive cardiovascular disease</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>GI Bleeding</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-17-72</u> to <u>8-21-72</u> that (I) (we) last saw the deceased alive on <u>8-21-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>V. Chitraplee</u>			23B. DATE SIGNED <u>8/21/72</u>		23C. PHYSICIAN'S NAME (Type) <u>V. Chitraplee</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8-24-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Maryland National Cem.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>			25B. NAME OF REGISTRAR <u>Richard H. ...</u>		25C. FUNERAL DIRECTOR <u>NUTTER, FUNERAL HOME 3035 W. NORTH AVE.</u>



C-652

72 08047

STATE OF MARYLAND - DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08047

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lonnie Grimes

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month Day Year

Hour

9:15 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

505 N. Patterson Park Avenue

3. DATE  
PRONOUNCED DEAD

Month Day Year

9:15 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. DATE OF BIRTH

1/19/19

10. AGE (In years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

505 N. Patterson Park Avenue

11. BIRTHPLACE (State or foreign country)

D.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ramon Grimes

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Printer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Maggie Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Betty Drumgoode 505 N. Patterson Park

19.

150X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Carcinoma of esophagus with

(A) IMMEDIATE CAUSE

Pulmonary metastases

DUE TO, OR AS A CONSEQUENCE OF:

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
8-21-7224A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/25/72

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

A.A. County Md

25A. DATE REC'D BY HEALTH DEPT.

AUG 23 1972

25B. NAME OF REGISTRAR

D. J. Johnson

25C. FUNERAL DIRECTOR

Joseph B. Locks

ADDRESS

1304 N. Central



25 0007

25 0007

25 0007

202 N. Hudson St. N.Y.  
Bklyn. N.Y.

202 N. Hudson St. N.Y.

Baron Hughes

Walter Long

202 N. Hudson St. N.Y.

202 N. Hudson St. N.Y.

X

1/10/14

H. G.

Refuse

No

WALTER LONG

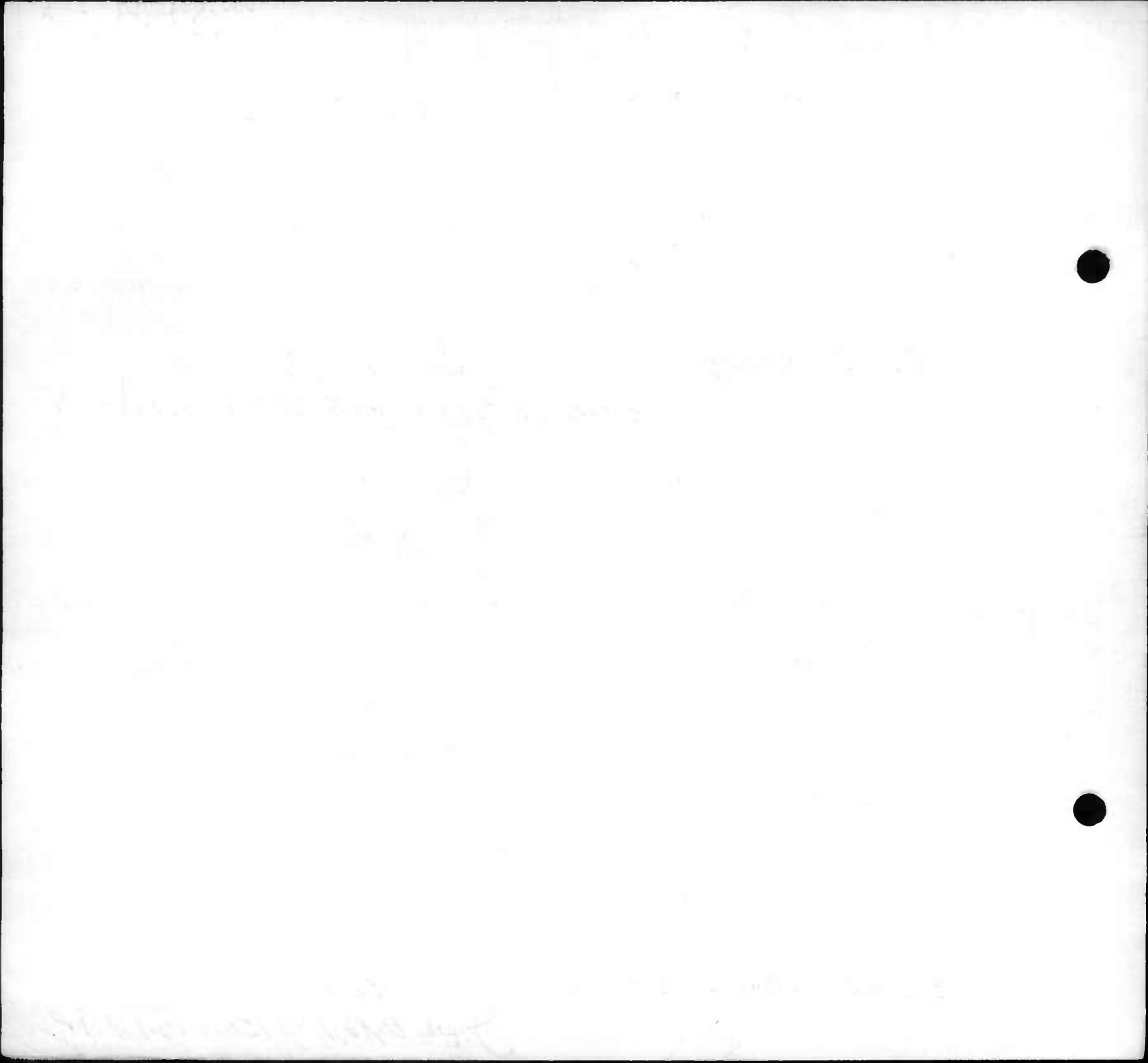
202 N. Hudson St. N.Y.  
Bklyn. N.Y.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08018		N	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>Mabel Little</u>				2. DATE AND HOUR OF DEATH <u>8/20/72</u> <u>11:55 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1601</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University of Maryland Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>700 Arlington Avenue, 21217</u>			
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/4/99</u>	9. AGE (In years last birthday) <u>73</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Daniel Porey</u>				14. MOTHER'S MAIDEN NAME <u>Susan Brimage</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-12-6395</u>		17. INFORMANT ADDRESS <u>Mae R. Hunt 25208 - Madison H</u>	
18. <u>430.01</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Intracerebral Hematoma</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>aug 20</u> 19 <u>72</u> to <u>aug 20</u> 19 <u>72</u> that <del>it</del> (we) last saw the deceased alive on <u>aug 20</u> 19 <u>72</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>It</del> (We) (did) <del>not</del> view the body after death.							
23A. SIGNATURE <u>Richard A. Tomasulo M.D.</u>				23B. DATE SIGNED <u>8/20/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Richard A. Tomasulo M.D.</u>				23D. ADDRESS <u>Univ. of Md. Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/24/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		25D. ADDRESS <u>1504 N. Central St</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08049

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN CLARENCE BLESSED</b> <b>JOHN C. BLESSED</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>August 21, 1972 6:05 P.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>North Carolina</b> B. COUNTY <b>V30</b>		6. CITY OR TOWN <b>Raleigh N.C.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Jan. 28, 1926</b>	10. AGE (In years last birthday) <b>46</b>	11. BIRTHPLACE (State or foreign country) <b>Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Clarence Dewey Blessed</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Genevieve ?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Joan E. Blessed, 5208 Falls of Neuse Road, Raleigh N.C. 27609</b>		ADDRESS	
19. <b>5719</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cirrhosis of liver</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>8/22/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>8/22/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>SECURITY PROCESS INC.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Shirley H. Wilson</b>	
25C. FUNERAL DIRECTOR <b>George Sanders &amp; Sons Inc.</b>		ADDRESS <b>1649 E. North Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 08050</span>	
T-352 <span style="font-size: 1.2em;">72 08050</span>				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">JANE TYDINGS</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">8-21-72 6:56 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">THE JOHNS HOPKINS HOSPITALS</span>			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">704</span> C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE,</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">806 N. BROADWAY</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9/1/84</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">87</span>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Manager Rooming House - Retired</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">TYDINGS, JOSEPH F.</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">WILSON, JANE R.</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-44-4709</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Joseph S. R. Tydings, Apt. 119 1504 S. Pentridge Baltimore Md. 21239</span>
18. <span style="font-size: 1.2em;">410.71</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">CARDIO RESPIRATORY ARREST</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">ACUTE MYOCARDIAL INFARCTION</span> <span style="font-size: 1.2em;">8 HRS.</span> (C) <span style="font-size: 1.2em;">ASCVD</span>  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 8 (A). <span style="font-size: 1.2em;">None</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">2:00 PM 8-21-1972</span> to <span style="font-size: 1.2em;">6:56 PM 8-21-1972</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">8-21-1972</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">C. Kent Osborne M.D.</span> DEGREE				23B. DATE SIGNED <span style="font-size: 1.2em;">8-21-72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">C. KENT OSBORNE M.D.</span> DEGREE				23D. ADDRESS <span style="font-size: 1.2em;">JOHNS HOPKINS HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">Aug. 25, 1972</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Greenmount Cem.</span>	
24D. LOCATION (City, town, or county) <span style="font-size: 1.2em;">Baltimore Md.</span>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">AUG 23 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Henry Sander &amp; Sons, Inc.</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">HENRY SANDER &amp; SONS, INC. Baltimore Md.</span>	

THE BUREAU OF THE ARMY

WASHINGTON, D.C.

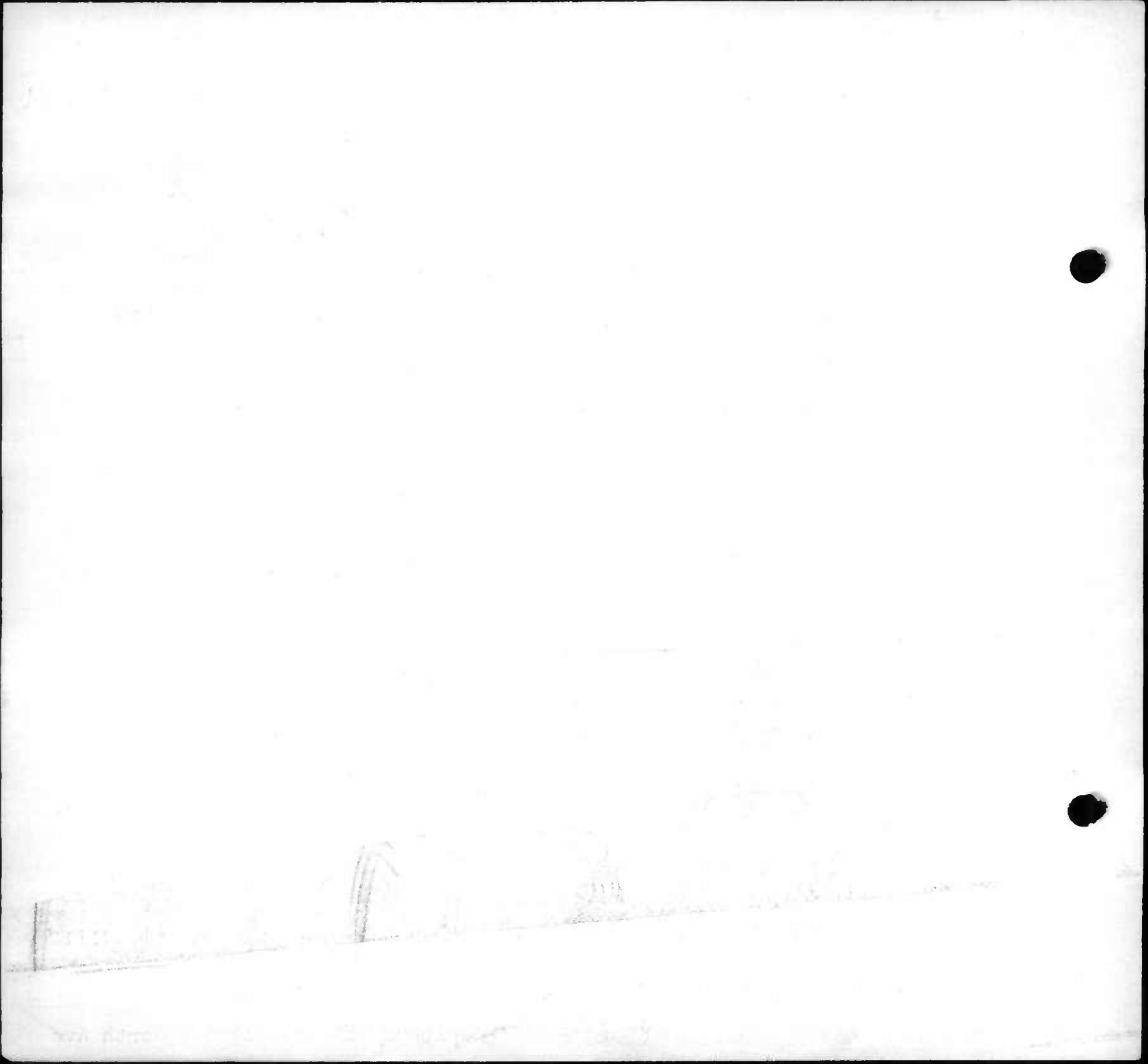
JOHN, JOSEPH

JOHN, JOSEPH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452 1		72 08051		BALTIMORE CITY HEALTH DEPARTMENT		72 08051	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DMH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAMS, JAMES</b>		2. DATE AND HOUR OF DEATH <b>8/22/72 12:29 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND STATE PENITENTIARY 954 FORREST ST BALTO 21202</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>UNKNOWN</b> B. COUNTY <b>402</b>			
				C. CITY OR TOWN <b>-</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>659 W Vine St</b>			
5. SEX <b>M</b>	6. RACE <b>NEGR</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/25/1910</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>ELICOTT CITY, MD</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>INSTITUTION RECORDS</b>			
18. <b>436.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PNEUMONIA</b> <b>L HEMIPARESIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CEREBROVASCULAR ACCIDENT</b>		<b>50 DAYS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b> <b>NONE</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>-</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>NA</b>		21F. HOW DID INJURY OCCUR? <b>NA</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>7/31</b> 19 <b>72</b> to <b>8/22</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert L. Gungell MD</b>				23B. DATE SIGNED <b>8/22/72</b>		23C. PHYSICIAN'S NAME (Type) <b>ROBERT L. GUNGELL MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/24/72</b>		24C. NAME of CEMETERY or CREMATORY <b>M<sup>1</sup> Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>			
ADDRESS <b>1206 W North Ave</b>							





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08052	
BIRTH NO. 72 08052		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <u>George Jessen III</u>		2. DATE AND HOUR OF DEATH <u>6/11/72</u> <u>8:50 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>DELAWARE</u> B. COUNTY <u>SUSSEX</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>		C. CITY OR TOWN <u>REHOBOTH BEACH</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u>		E. STREET AND NUMBER <u>RD # 1 BOX 324 E</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 6 71</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <u>1</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Milford, Delaware</u>	
13. FATHER'S NAME <u>GEORGE JESSEN JR.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>HELEN G. WARRINGTON</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Helen Jessen Rehoboth Beach, Delaware</u>	
18. <u>5-19-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteric Encephalopathy</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Conductionary Arrest</u> <u>Chronic Lung + Heart Disease - Etiology?</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from <u>12/10/68</u> to <u>6/11/72</u> and that (I) (we) last saw the deceased alive on <u>6/11/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Michael V. Johnston, M.D.</u>		23B. DATE SIGNED <u>6/11/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael V. JOHNSTON M.D.</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY <u>Memorial Park Cemetery, Milton, Delaware</u>		24D. LOCATION (City, town, or county) (State) <u>Delaware</u> <u>Rehoboth Beach</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 23 1972</u>		25B. NAME OF REGISTRAR <u>A. J. Johnston</u>	
25C. FUNERAL DIRECTOR <u>Johnston</u>		25D. ADDRESS <u>Rehoboth Beach</u>	

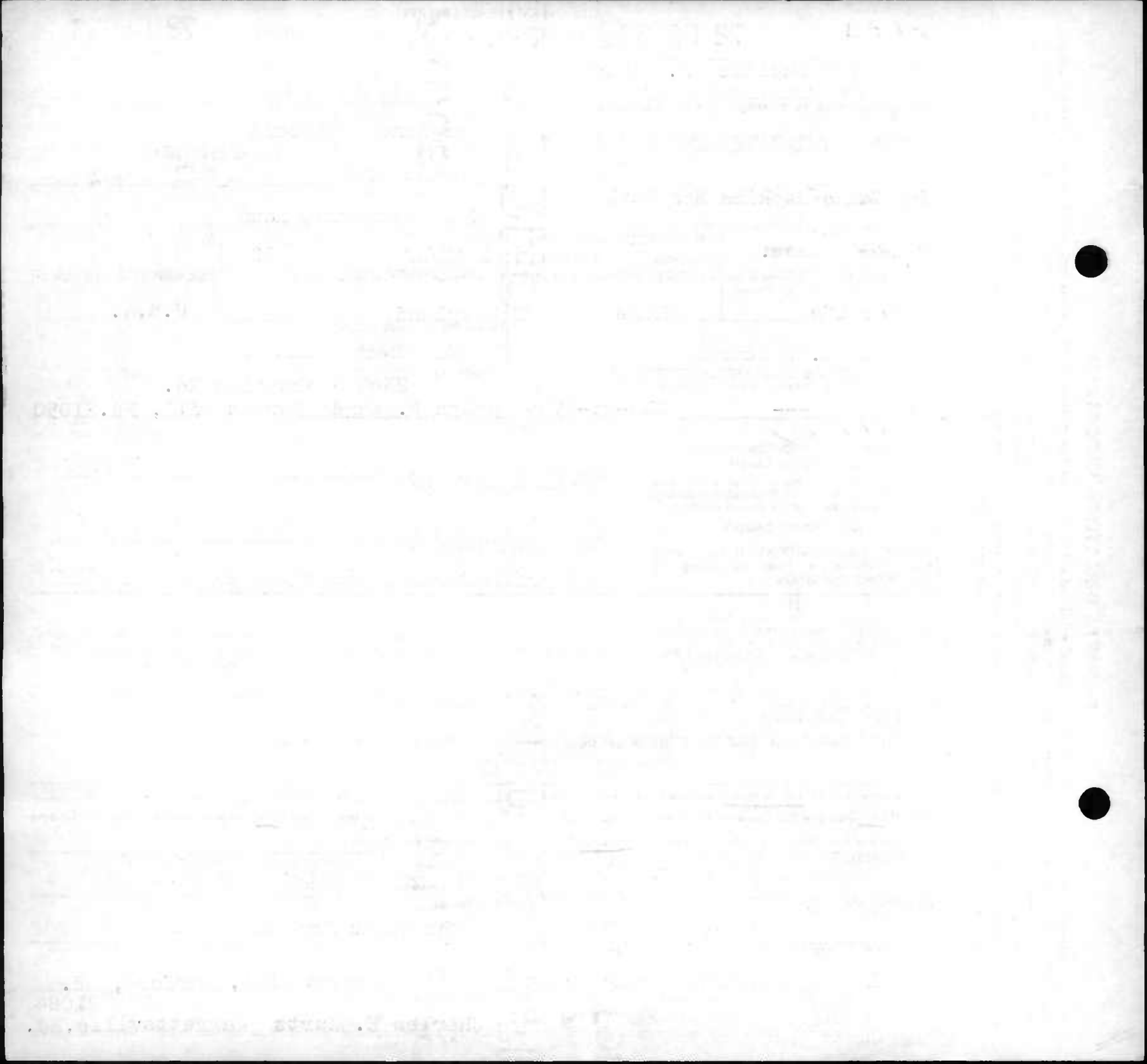
W. T. 1900. J. 1900.

W. T. 1900. J. 1900.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08053</b>
<b>W-630</b>		<b>72 08053</b>		<b>CERTIFICATE OF DEATH</b>
BIRTH NO. <b>W-630</b>		STATE OF <b>MARYLAND-DEMD</b>		
1. NAME OF DECEASED (Type or Print) <b>Lucille S. Ward</b> <i>Ward, Lucille</i>		2. DATE AND HOUR OF DEATH <b>8/21/72</b> <i>1557/p</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>		C. CITY OR TOWN <b>Forest Hill</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>2300 Rockspring Road</b>		
5. SEX <b>Female</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/22/19</b>	9. AGE (In years last birthday) <b>53</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John C. Smithson</b>		
14. MOTHER'S MAIDEN NAME <b>Elizabeth Phillips</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>219-05-1724</b>		17. INFORMANT <b>Ralph R. Ward</b> ADDRESS <b>2300 Rockspring Rd. Forest Hill, Md. 21050</b>		
18. <b>441.21</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>18 hrs.</b>
(C) <b>Renal failure, Pulmonary infarction</b>				<b>11 days</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>8/9/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Aortic aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>8/9</b> 19 <b>72</b> to <b>8/21</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>8/21</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Jack A. Roth</i>		23B. DATE SIGNED <b>8/21/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Jack A. Roth</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/24/1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Deer Creek</b>
24D. LOCATION <b>Forest Hill, Harford, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		
25B. NAME OF REGISTRAR <i>Lidney Whorton</i>		25C. FUNERAL DIRECTOR <b>Charles E. Kurtz</b> ADDRESS <b>Jarrettsville, Md. 21084</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 08054</u>	
BIRTH NO. <u>W-324</u>		72 08054 <b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>MILDRED MARY WEITZEL</b>		2. DATE AND HOUR OF DEATH <b>August 14, 1972</b> <span style="float: right;">12 <sup>10</sup>/<sub>12</sub> P.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>7710 Daniels Ave.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2735</b>	
		C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>7710 Daniels Ave.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1/30/1908</b>
		9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tele. Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto City Schools</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Cavan</b>		14. MOTHER'S MAIDEN NAME <b>Ida Harper</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>1203146381</b>	17. INFORMANT ADDRESS <b>1;604 Spur Rd. Mr. Walter R. Weitzel Yardley Pa.</b>
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardiac Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>HASCPD</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>  <b>years</b>  <b>year</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NO</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1972</b> to <b>Aug</b> 1972, that (I) (we) last saw the deceased alive on <b>8/13</b> 1972 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>See H Beck</b>		23B. DATE SIGNED <b>8/14/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. George Beck</b>		23D. ADDRESS <b>6012 Harford Rd., Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/17/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Laurel Hill Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>West Balacynwyd Penna.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 23 1972</b>		25B. NAME OF REGISTRAR <b>Anthony W. ...</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc., Balto. Md</b>		25D. ADDRESS <b>21214</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 14-630				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08055			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
Hannah D. HARDY				8-22-72 5 A. M.				1513 E. Federal St 21213			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. SEX				6. RACE			
A. STATE Maryland				Female				Negro			
B. COUNTY				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
C. CITY OR TOWN Baltimore				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated				12-5-07			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				9. AGE (In years last birthday) 64				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
E. STREET AND NUMBER 1513 East Federal Street				11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Hilley Taft				14. MOTHER'S MAIDEN NAME Bessie Hornes				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 135-16-4298				17. INFORMANT Mrs. Bessie Skipper 1513 E. Federal St. 21213				ADDRESS			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
I				H-AS-CVD				Several yrs			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)				(B) obesity				4 4			
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) no			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 1970 to 8-21-1972				that (I) (we) last saw the deceased alive on 8-21-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Herman Schaefer MD				23B. DATE SIGNED 8-22-72							
23C. PHYSICIAN'S NAME (Type) HERMAN SCHAEFER, M.D.				23D. ADDRESS B.C. Hosp. 4940 Eastern Ave. 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8-25, 72				24C. NAME of CEMETERY or CREMATORY Maryland National Pk,			
								24D. LOCATION (City, town, or county) Laurel, Maryland			
25A. DATE REC'D BY HEALTH DEPT. AUG 23 1972				25B. NAME OF REGISTRAR Sidney W. Jones, Jr.				25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213			



VALLEY FLOOR

about 1000 ft. and 1100 ft.

about 1000 ft.

about 1000 ft.

about 1000 ft.

about 1000 ft.

about 1000 ft.

about 1000 ft.

about 1000 ft.

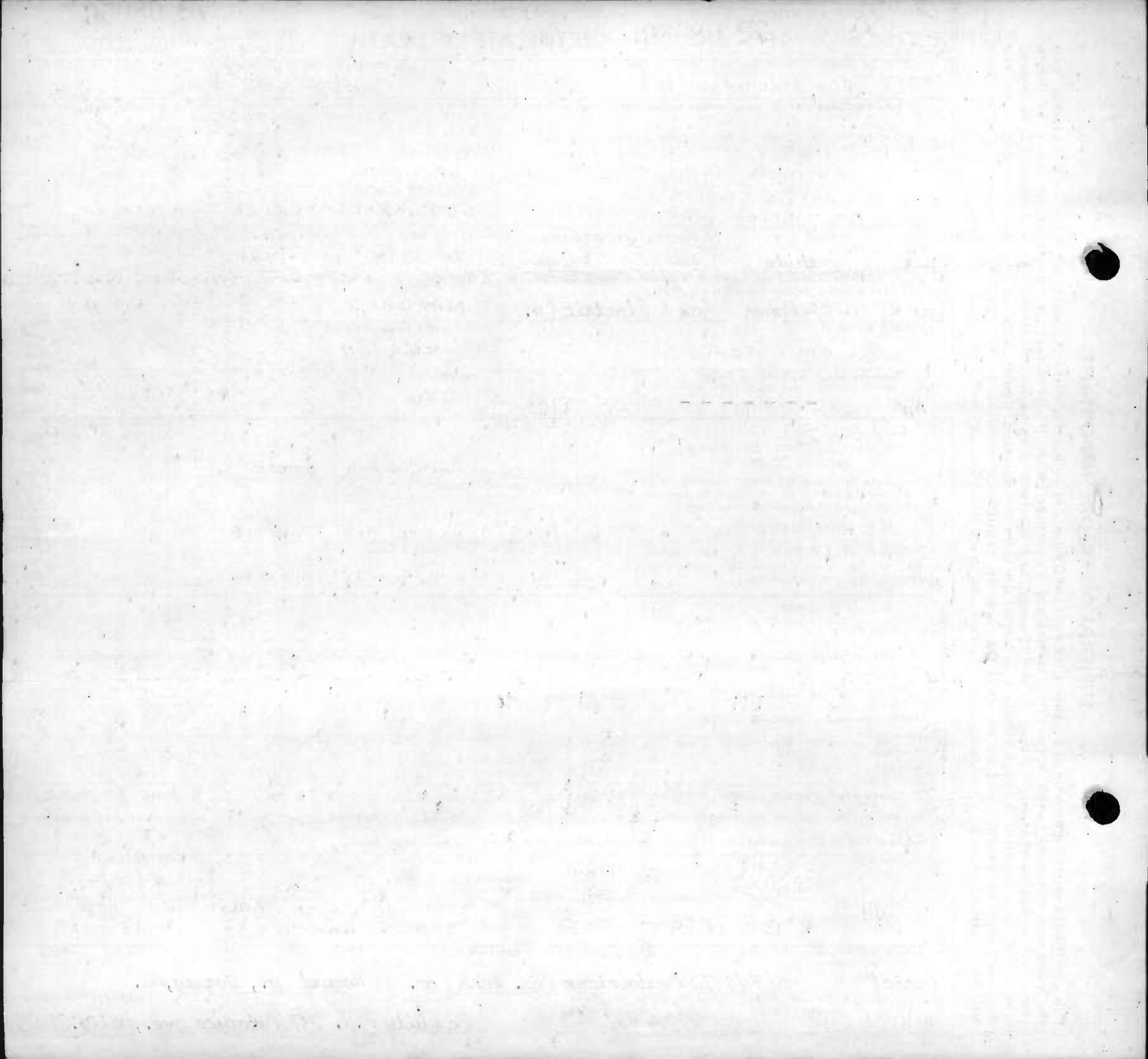
about 1000 ft.

about 1000 ft.

# FUNERAL DIRECTOR: IMPORTANT

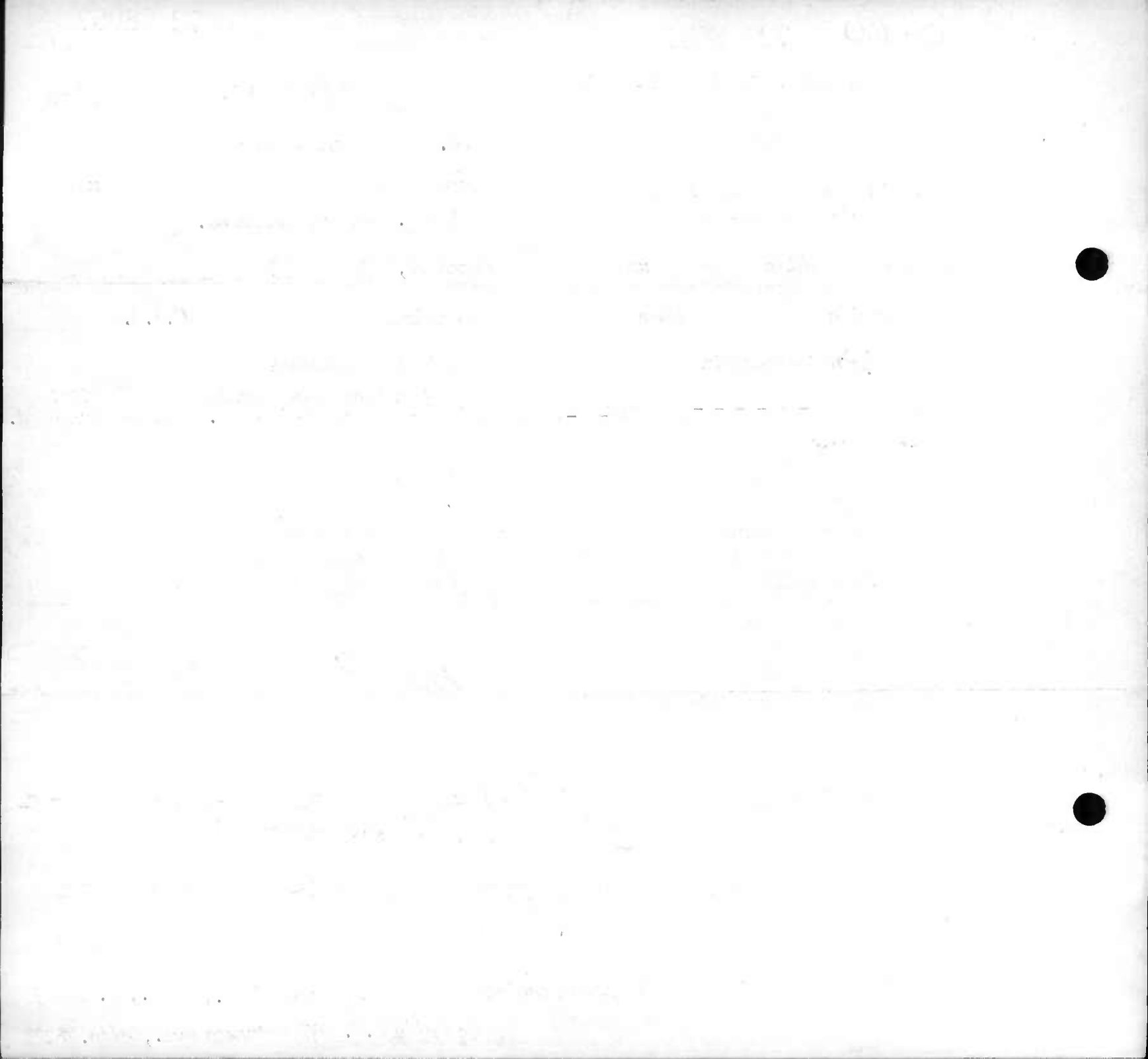
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-200		72 08056		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08056	
BIRTH NO.				STATE OF MARYLAND - DEPT.			
1. NAME OF DECEASED (Type or Print) FOX, THOMAS H.				2. DATE AND HOUR OF DEATH 8/20/72 6:55 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 SOUTH BALTIMORE GEN. HOSPITAL 3001, S. HANOVER STREET BALTIMORE MARYLAND 21230				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male				6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas RETIRED Maker				10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		9. AGE (In years last birthday) 78	
13. FATHER'S NAME WILLIAM FOX.				14. MOTHER'S MAIDEN NAME VIRGINIA		11. BIRTHPLACE (State or foreign country) MARYLAND.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 215057027A		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT WIFE				ADDRESS AS ABOVE.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 8-13-1972 to 8/20/1972, that (A) (we) last saw the deceased alive on 8/20/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. B. PATEL				23B. DATE SIGNED 8/20/72		23C. PHYSICIAN'S NAME (Type) R. B. PATEL	
23D. ADDRESS 3001, S. HANOVER ST BALTO MD.				23E. ADDRESS Mc Guffy F.H. 237 Patapsco Ave., Balto. 21225			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/24/1972		24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park Cem.	
24D. LOCATION Howard Co., Dorsey, Md.				24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972				25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Mc Guffy F.H.	



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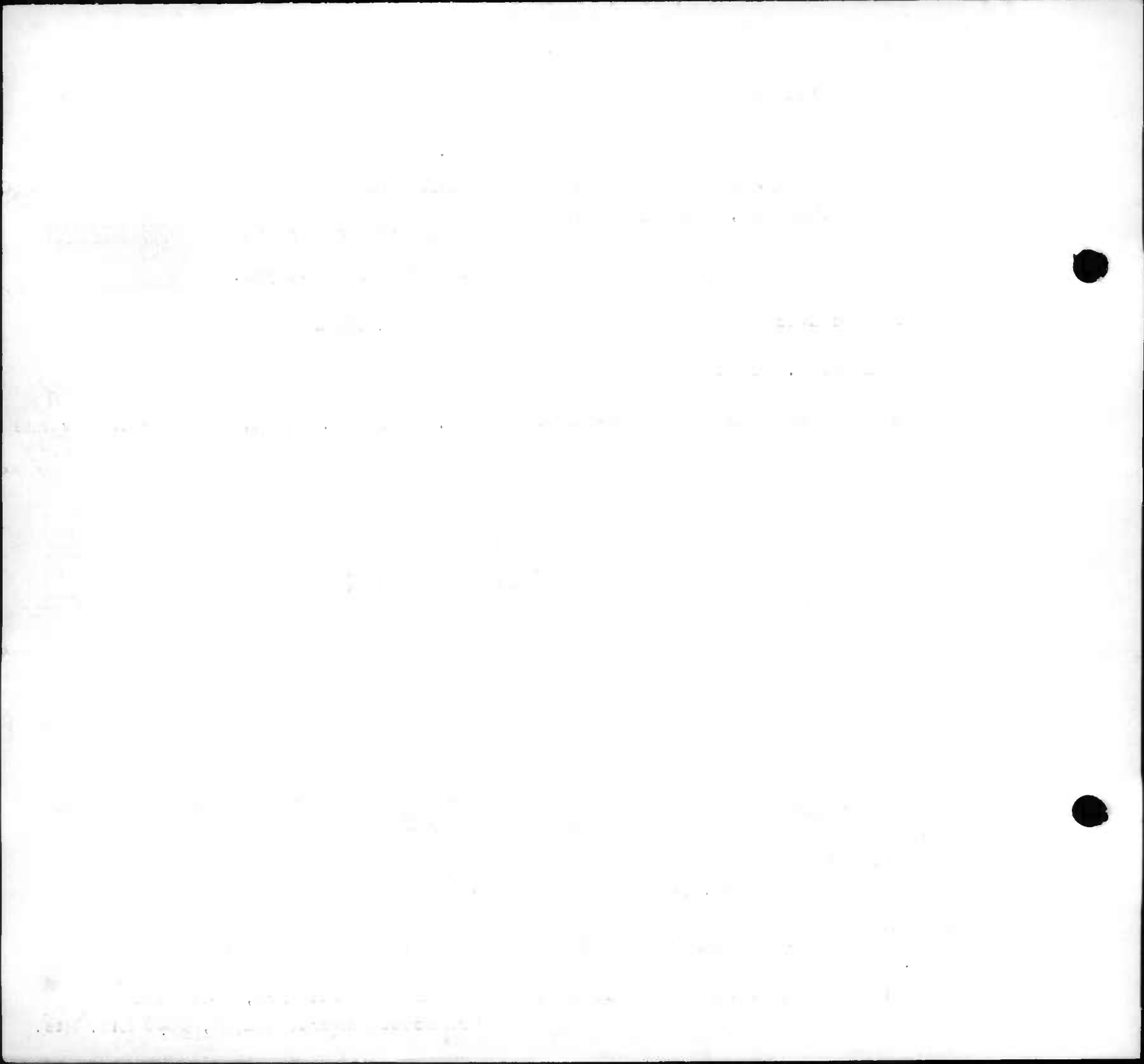
S-480		72 08057		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.		72 08057	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>MRS. THERESA F. SKELLY</b>				2. DATE AND HOUR OF DEATH <b>8/20/1972</b> <b>7 40 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Anne Arundel</b>				5. STATE OF MARYLAND - <b>DENY</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME &amp; HOSPITAL BALTIMORE, MARYLAND</b>				C. CITY OR TOWN <b>Glen Burnie</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <b>401 E. Furnace Branch Rd.</b>				6. SEX <b>Female</b>				7. RACE <b>White</b>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. DATE OF BIRTH <b>March 21, 1899</b>				10. AGE (In years last birthday) <b>73</b>			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				12. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				13. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
14. FATHER'S NAME <b>John Hartenstein</b>				15. MOTHER'S MAIDEN NAME <b>Tillie Wehgratner</b>				16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				18. SOCIAL SECURITY NO. <b>217-22-9513</b>				19. INFORMANT <b>Daughter Glen Burnie Cathaleen Hartenstein</b>			
20. ADDRESS <b>21061 309 E. Furnace Branch Rd.</b>				21. CAUSE OF DEATH <b>Cardiopulmonary arrest.</b>				22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.				25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
26. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>8/19/72</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>				20A. AUTOPSY? (Yes or No) <b>NO</b>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>8/20/72</b>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <b>8/20</b> 19 <b>72</b> to <b>8/20</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				23A. SIGNATURE <b>M. YOUSUF SIDDIGI M.D.</b>			
23B. DATE SIGNED <b>8/30/72</b>				23C. PHYSICIAN'S NAME (Type) <b>M. YOUSUF SIDDIGI M.D.</b>				23D. ADDRESS <b>237 Patapsco Ave., Balto. 21225</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8/24/1972</b>				24C. NAME of CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>			
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Balto., Md. 21225</b>				25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>				25B. NAME OF REGISTRAR <b>Shirley Johnson</b>			
25C. FUNERAL DIRECTOR <b>McCallister, 237 Patapsco Ave., Balto. 21225</b>				25D. ADDRESS				25E. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

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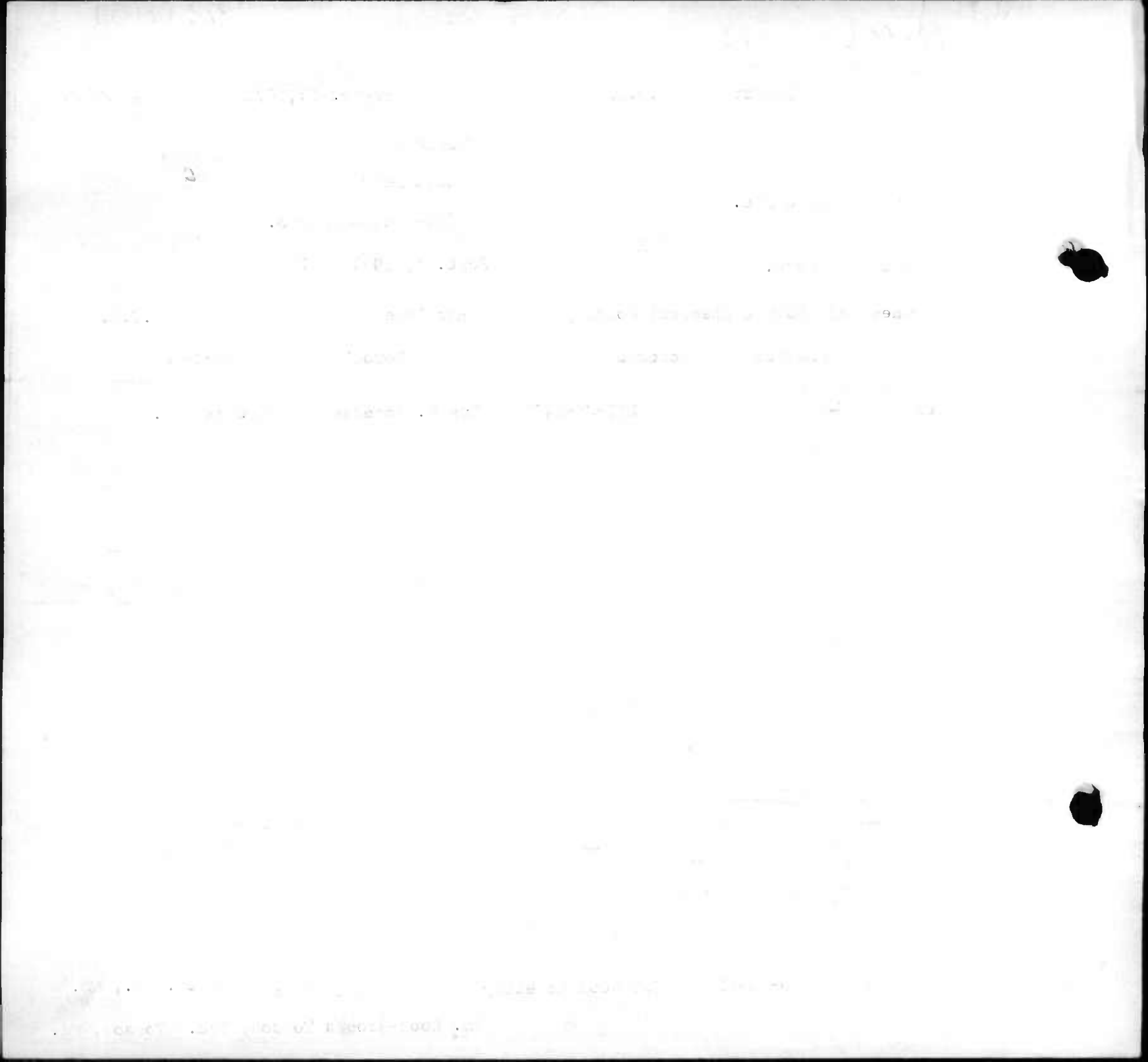
BALTIMORE CITY HEALTH DEPARTMENT 72 08058 CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DHMH	
BIRTH NO. T-630		1. NAME OF DECEASED (Type or Print) Lewin Trout		2. DATE AND HOUR OF DEATH 8-22-72 1:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4014 Hayward Avenue Baltimore Maryland 21215			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 2788 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4014 Hayward Avenue		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/8xx93	9. AGE (In years last birthday) 79 yrs.	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME James G. Trout		
14. MOTHER'S MAIDEN NAME Rowe			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I		
16. SOCIAL SECURITY NO. 217-22-4139			17. INFORMANT Mrs. Jonson L. Trout, 4014 Hayward Avenue		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure Angina pectoris					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-17-72 to 8-22-72, that (I) (we) last saw the deceased alive on 8-3-72, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MARCIO M. MENDOZA MD		23B. DATE SIGNED 8-23-72		23C. PHYSICIAN'S NAME (Type) MARCIO M. MENDOZA MD	
23D. ADDRESS 5820 YORK RD		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 8/25/72		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Arma Cost Funeral Chapel	
25D. ADDRESS 4600 Lib. Hts. 21207					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

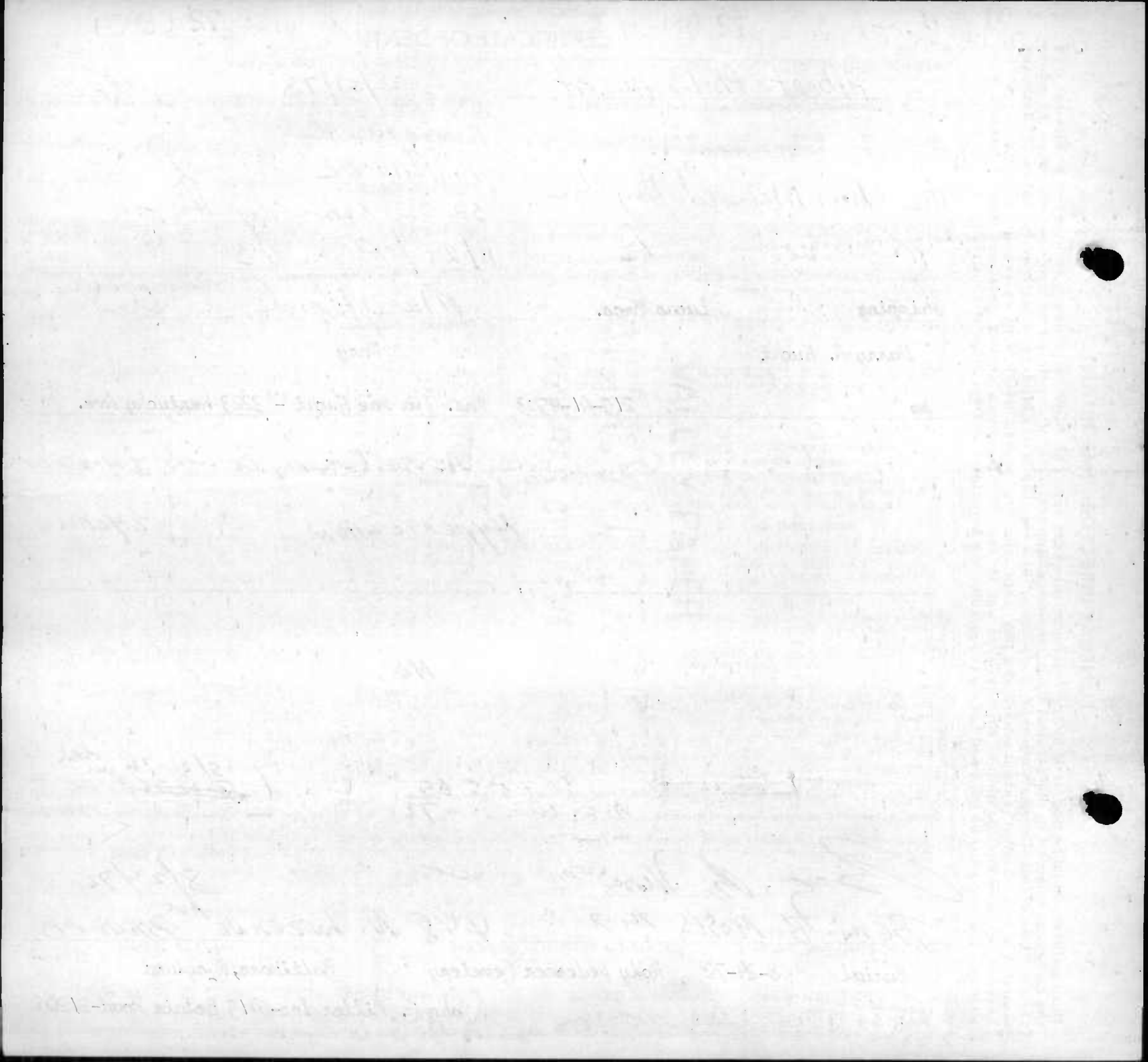
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08060</b>	
BIRTH NO. <b>H-230</b>		72 08060	
1. NAME OF DECEASED (Type or Print) <b>Albert Philip Hucht</b>		2. DATE AND HOUR OF DEATH <b>8/21/72 11<sup>10</sup> p.m. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Union Memorial Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2633</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3223 Kentucky Ave</b>	
5. SEX <b>m</b>	6. RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/28/08</b>
9. AGE (In years last birthday) <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Harry A. Hucht</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-9503</b>	
17. INFORMANT <b>Mrs. Eva Mae Hucht - 3223 Kentucky Ave.</b>		ADDRESS	
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>ACUTE CORONARY OCCLUSION IMMEDIATE</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-5-69</b> 19 to <b>8/21-72</b> 19, that (I) (we) last saw the deceased alive on <b>AUG. 20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>B. B. MOSES, MD</b>		23B. DATE SIGNED <b>8/24/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>BEN. B. MOSES, MD</b>		23D. ADDRESS <b>448 N. LUZERNE BALD. MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-24-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Houghton</b>	
25C. FUNERAL DIRECTOR <b>John C. Miller Inc</b>		ADDRESS <b>6415 Belair Road-21206</b>	



51-14-80 gpw

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-612		72 08061		72 08061	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
FRANCES E. SKARBEK		1 <sup>50</sup> A.M. 8-22-72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE MARYLAND, BALTIMORE 701			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 805 N. KENWOOD AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-04	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH RATAJCZAK		14. MOTHER'S MAIDEN NAME HELEN RATAJCZAK (last name)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mildred Wilkinson 6812 fact ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Atherosclerotic coronary vascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from 7-30-1972 to 8-22-1972 that (I) (we) last saw the deceased alive on 8-22-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE R. Lanham M.D.	
23B. DATE SIGNED 8-22-72		23C. PHYSICIAN'S NAME (Type) Richard J. Lanham M.D.		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. 21224 BALTIMORE CITY HOSPITALS	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 8-25-72		24C. NAME OF CEMETERY OR CREMATORY St Stanislaus Cemetery	
24D. LOCATION Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR WALTER DABROWSKI	
25C. FUNERAL DIRECTOR WALTER DABROWSKI		25D. ADDRESS 1005 DUNDALK AVENUE		21224	

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K-260 72 08062 STATE OF MARYLAND - DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08062

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harold Keyser		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 8 21 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 116 W. University Pkwy		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 21 72 8:18 a. M.	
6. SEX male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10/7/'78		10. AGE (In years last birthday) 53	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Superior Uniform Co.		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Estelle R. Scates		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes	
17. SOCIAL SECURITY NO. 213-03-6092		18. INFORMANT Mr. Charles V. Keyser	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Russell S. Fisher, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 8/21/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/25/'72	
24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Frederick, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR John A. Moran, Jr.	
25C. FUNERAL DIRECTOR 3000 E. Baltimore St. Baltimore, Md. 21224		25D. ADDRESS	

VS 151-REV. 7/1/68



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# FUNERAL DIRECTOR: IMPORTANT

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4-320		72 08063		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08063	
BIRTH NO.				STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) MARY A. HODGE				2. DATE AND HOUR OF DEATH 8/18/72 10:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME & HOSPITAL.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 301			
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/14/1881	
9. AGE (In years last birthday) 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN		11. BIRTHPLACE (State or foreign country) AKRON, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NOAH HODGE				14. MOTHER'S MAIDEN NAME SARAH ASHURN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-039526-A		17. INFORMANT ADDRESS HOSPITAL CHART	
18. 41241 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD OLD AGE. (C) Probable space occupying lesion.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE long standing long standing	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/29/1968 to 8/18/1972 that (I) (we) last saw the deceased alive on 8/18/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Satpal Singh, M.D., DEGREE				23B. DATE SIGNED 8.18.72		23C. PHYSICIAN'S NAME (Type) SATPAL SINGH M.D., DEGREE	
23D. ADDRESS Church Home & Hospital.							
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 8-21-72		24C. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD		ADDRESS 6300 York RD	

7/5/72

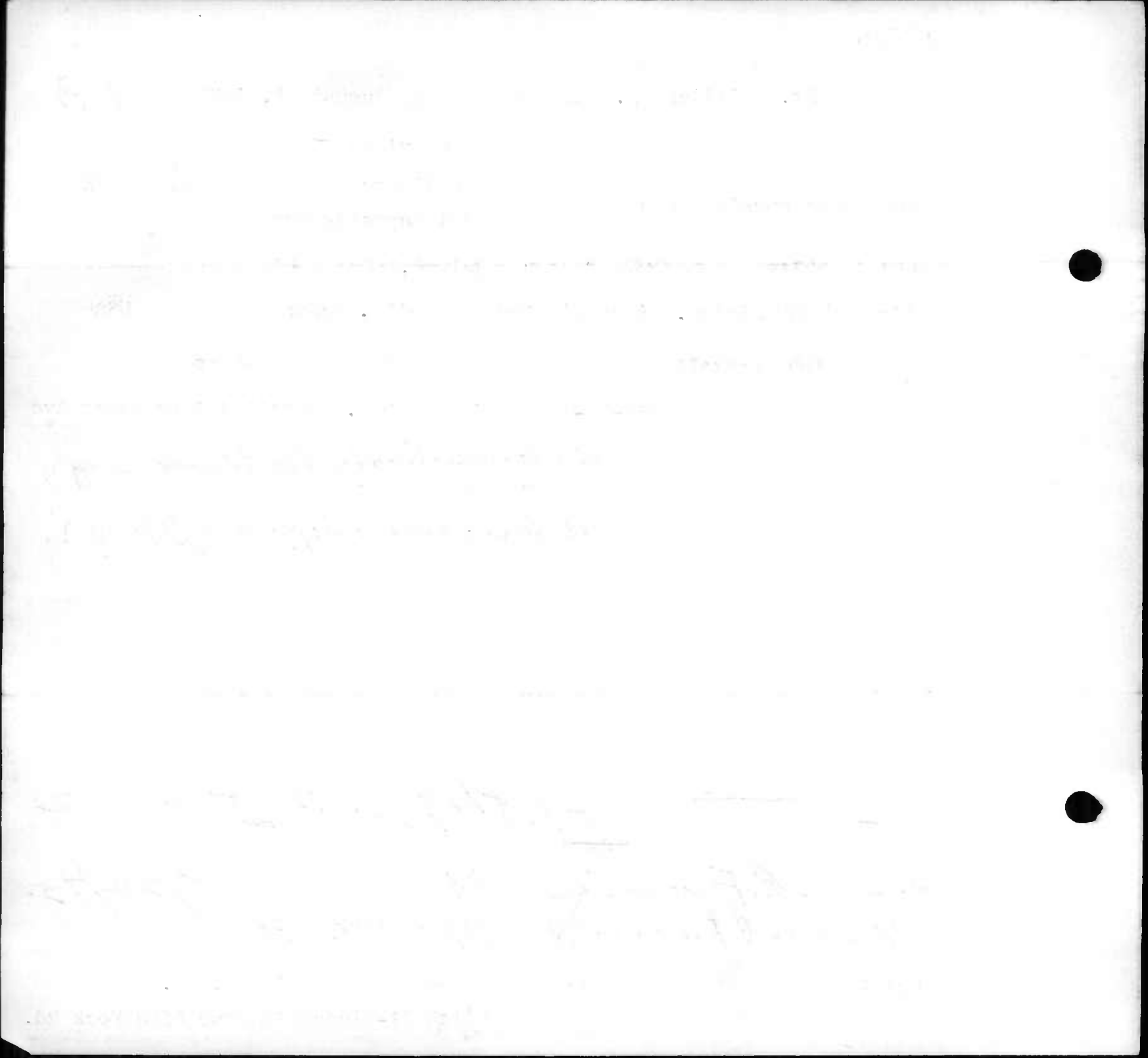
No Prev. Address.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

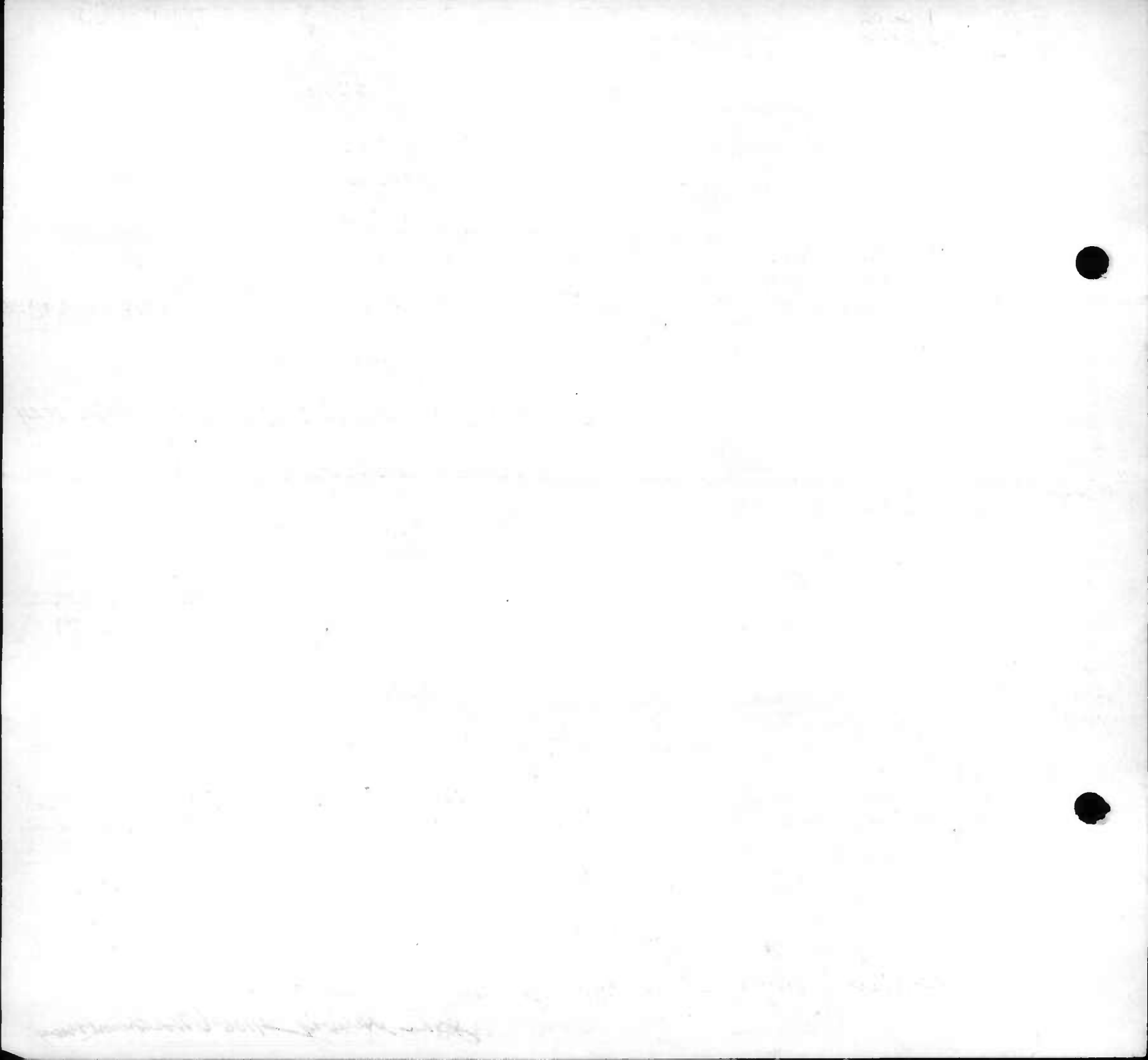
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 08064</u>	
BIRTH NO. <u>K-340</u>		72 08064		STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mr. William J. Kettell</u>				2. DATE AND HOUR OF DEATH <u>August 21, 1972</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Long Green Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? <u>XXXXXX</u> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>401 Regester Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1888</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Steam Fitter. Riggs Distler</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Phila. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Ralph Kettell</u>			14. MOTHER'S MAIDEN NAME <u>? Down</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>216-09-1698</u>		17. INFORMANT <u>Miss Ruth H. Kettell</u> ADDRESS <u>401 Regester Ave</u>		
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic heart disease, 2 yr.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Arteriosclerosis, general, 10 yr.</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <u>8/17</u> 19 <u>72</u> to <u>8/21</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <u>Norman R. Freeman</u>				23B. DATE SIGNED <u>8/22/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>NORMAN R. FREEMAN</u>				23D. ADDRESS <u>11 W 29th St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/23/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oaklawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 24 1972</u>		25B. NAME OF REGISTRAR <u>Andrew Thornton</u>		25C. FUNERAL DIRECTOR <u>Mitchell Wiedefeld</u>		ADDRESS <u>Home 6500 York Rd.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08065		72 08065	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND - DEATH	
BIRTH NO. <b>J-520</b>				1. NAME OF DECEASED (Type or Print) <b>JOHN M. JONES</b>		2. DATE AND HOUR OF DEATH <b>2:10 PM. on Aug 18, 1972</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH Home &amp; Hospital Baltimore MD.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>602</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>6-17-1895</b> 9. AGE (in years last birthday) <b>77</b>		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>				13. FATHER'S NAME <b>WILSON JONES</b>			
14. MOTHER'S MAIDEN NAME <b>SARAH RIGGS</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>224-26-1635</b>				17. INFORMANT <b>Mrs Harriet Swin</b> ADDRESS <b>205 N. Rose St #24</b>			
18. <b>519.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Ante Pulmonary Oedema</b> <b>Chronic Obstructive Pulmonary Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/4/1972</b> to <b>8/18/1972</b> that (I) (we) last saw the deceased alive on <b>8/18/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. Yousof Siddiqui MD</b>				23B. DATE SIGNED <b>8/18/72</b>		23C. PHYSICIAN'S NAME (Type) <b>M. YOUSUF SIDDQUI MD</b>	
23D. ADDRESS <b>Church Home &amp; Hosp. 100 N. Broadway Baltimore MD 21231</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 21/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Mem</b>		24D. LOCATION (City, town, or county) (State) <b>Bal Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Siddiqui</b>		25C. FUNERAL DIRECTOR <b>John Henry</b>		ADDRESS <b>4106 E. Northampton Hwy</b>	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

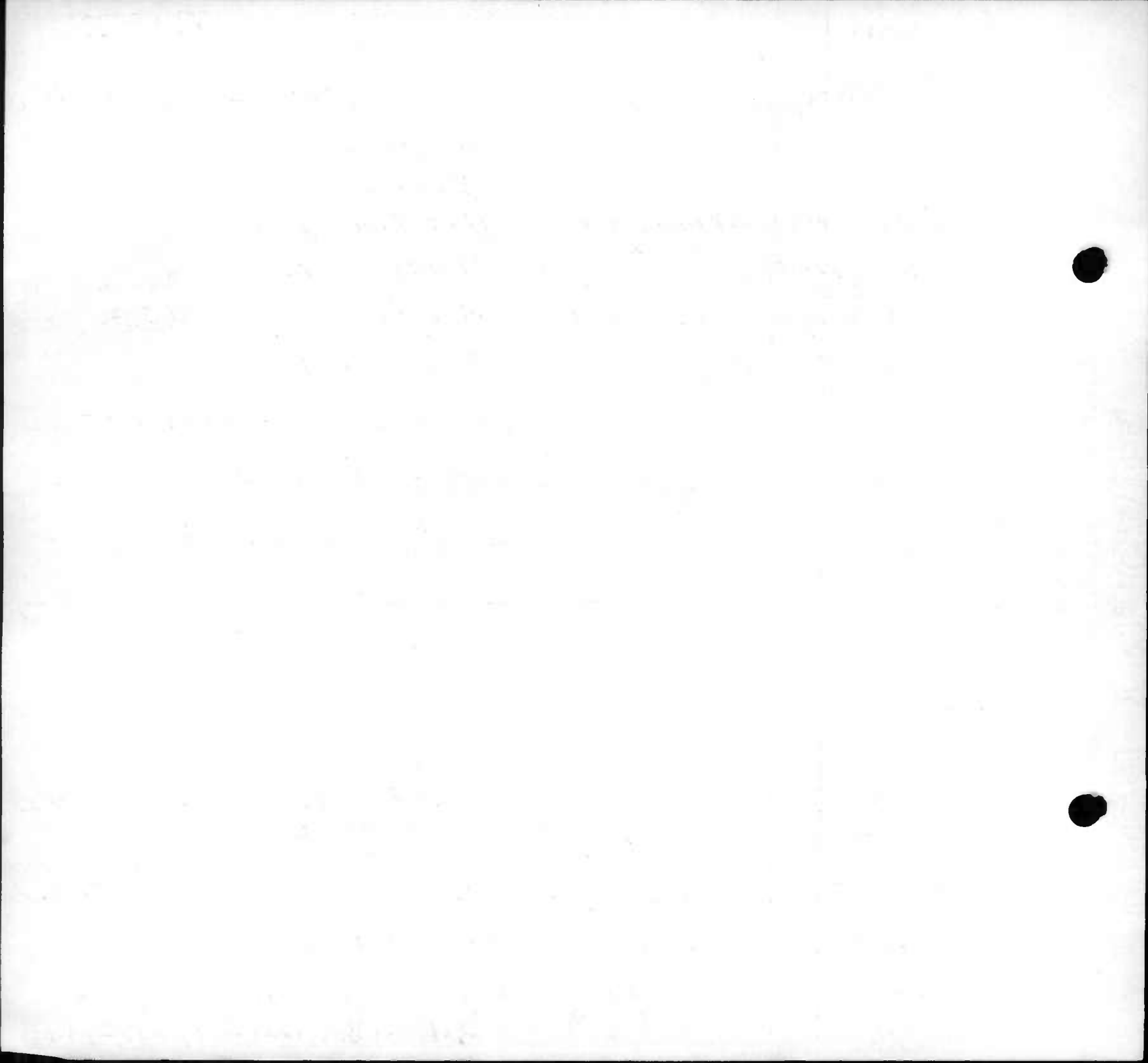
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08066</u>	
B-650 72 08066				STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <b>BYRON, LOUIS ELLSWORTH</b>				2. DATE AND HOUR OF DEATH <b>AUGUST 19, 1972 11:50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2102 21230</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1153 WEST HAMBURG STREET</b>					
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/11/00</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MOULD WORKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GLASS</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM BYRON</b>			14. MOTHER'S MAIDEN NAME <b>FLORA KLINE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-05-8178</b>	17. INFORMANT <b>WILKENS AVENUES BALTO MD</b> <b>ST AGNES HOSPITAL'S RECORDS CATON &amp;</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>412.314250.9</b> (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebrovascular accident, Diabetes Mellitus</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>2 yrs</b>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>AUGUST 8</b> 19 <b>72</b> to <b>AUGUST 19</b> 19 <b>72</b> , that <b>X</b> (we) last saw the deceased alive on <b>AUGUST 19</b> 19 <b>72</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) <b>XXXX</b> view the body after death.					
23A. SIGNATURE <b>Vincent H. Wang, M.D.</b>				23B. DATE SIGNED <b>08/20/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>VINCENT H WANG, M.D.</b>				23D. ADDRESS <b>BALTO MD 21229 ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-23-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Howard Co. Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Hinton</b>		25C. FUNERAL DIRECTOR <b>Hubbard funeral Home Inc. 4107 Wilkens Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

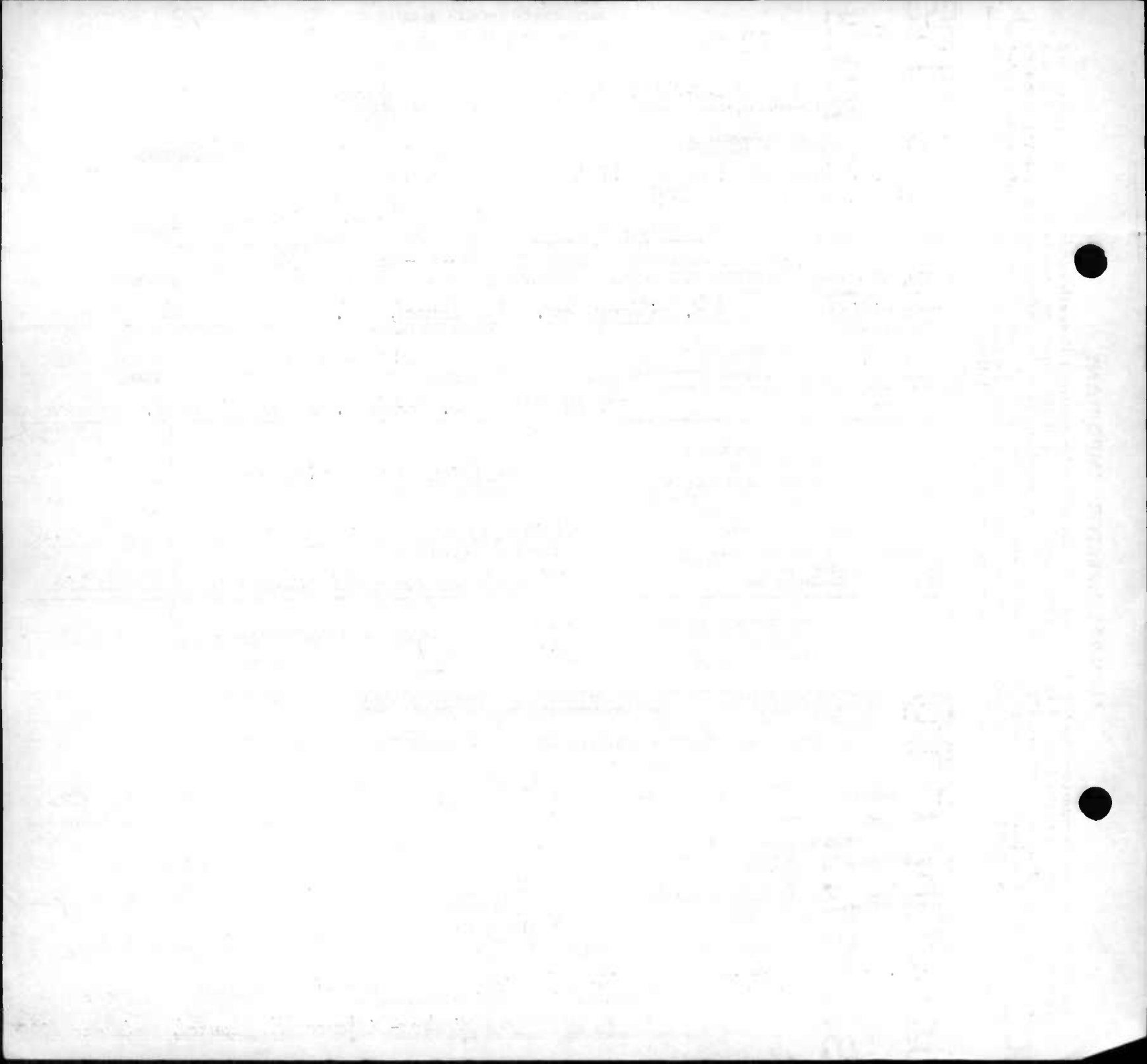
BALTIMORE CITY HEALTH DEPARTMENT				72 08067		72 08067	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <u>Robert L. Wayne</u>				2. DATE AND HOUR OF DEATH <u>8/21/72</u> <u>7:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Caton Manor Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1903</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>8/9/89</u>		9. AGE (In years last birthday) <u>83</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Robert L. Wayne</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Anna H. Wayne</u>	
18. <u>4/12-41</u> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> 19 <u>72</u> to <u>8/24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Herbert J. Levickas, MD</u>				23B. DATE SIGNED <u>8/22/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Herbert J. Levickas</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>8/25/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 24 1972</u>				25B. NAME OF REGISTRAR <u>Androse Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1228 Sulphur Sp. Rd</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-655		72 08068		BALTIMORE CITY HEALTH DEPARTMENT		7		72 08068	
BIRTH NO.		72 08068		CERTIFICATE OF DEATH		REG. NO.		72 08068	
1. NAME OF DECEASED (Type or Print) <u>JAMES CARMAN</u>				2. DATE AND HOUR OF DEATH <u>August 19, 1974 2:05 AM.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>				A. STATE <u>DELAWARE</u>		B. COUNTY <u>SUSSEX</u>			
				C. CITY OR TOWN <u>HARBESON</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>STAR ROUTE BOX 16</u>					
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-11-12</u>		9. AGE (In years lost birthday) <u>59</u>		10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>supervision</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>St. Highway Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Laurel, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>HAVILLAM CARMAN</u>				14. MOTHER'S MAIDEN NAME <u>ALLIE GERMAN</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>221 10 1934</u>		17. INFORMANT <u>Mrs. Bertha W. Carman</u>			
						ADDRESS <u>Star Rt. Harbeson Del.</u>			
18. <u>486X 1 + 189.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MYOCARDIAL INFARCTIONS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>PNEUMONIA, GI BLEED</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>3 HOURS</u> <u>24+ HOURS</u> <u>10 DAYS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Metastatic Hypernephroma to Brain</u>									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>JULY 21</u> 19 <u>72</u> to <u>AUGUST 19</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>August 19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>John B. Welch M.D., Ph.D.</u>				23B. DATE SIGNED <u>8/19/72</u>					
23C. PHYSICIAN'S NAME (Type) <u>JOHN WELCH M.D., Ph.D.</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSP, BALT, MD</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>8/22/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Odd Fellows Cemetery</u>		24D. LOCATION <u>Laurel Sussex Delaware</u>		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 24 1972</u>				25B. NAME OF REGISTRAR <u>Audrey Johnson</u>		25C. FUNERAL DIRECTOR <u>Winston Disharoon FH Laurel, Delaware 19956</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-350		72 C8069		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08069	
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) BIDEN ANNIE BARBARA				2. DATE AND HOUR OF DEATH 08/19/72 1:00PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2327 HAMMONDS FERRY ROAD 21227			
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06/26/89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 83		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOSE PH NARER				12. CITIZEN OF WHAT COUNTRY? U S A			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE INFARCT AND MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH ACUTE INFARCT AND MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EDEMA (B) DUE TO, OR AS A CONSEQUENCE OF: HSCVD (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 5 days	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 08/06/72 19 to 08/19/72 19, that (X) (we) last saw the deceased alive on 08/19/72 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE JOSE APTER, M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) JOSE APTER, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-22-1972		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR Lidney Johnson		25C. FUNERAL DIRECTOR Hubbard Funeral Home, Inc.		25D. ADDRESS 4107 Wilkens Ave.	



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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08070</u>
P-610		72 08070		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		PRIEBE, SARAH CONSTANCE		AUGUST 19, 1972 6:50P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL</b> <b>WILKENS &amp; CATON AVES.</b> <b>BALTIMORE, MARYLAND 21229</b>		A. STATE <b>MD.</b> B. COUNTY C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>528 SLONGWOOD ST.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>05 04 07</b>	9. AGE (In years last birthday) <b>65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>
13. FATHER'S NAME <b>JOHN BIANCO</b>		14. MOTHER'S MAIDEN NAME <b>CONCETTA CAMARATA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-22-1202</b>		17. INFORMANT <b>202 ST AGNES RECORDS WILKENS &amp; CATON AVES</b>
18. <b>250.71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>C.V.A.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>diabetes, hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>AUGUST 17, 1972</b> to <b>AUGUST 19, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>AUGUST 19, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>F. Khorasani</b>				23B. DATE SIGNED <b>8/19/72</b>
23C. PHYSICIAN'S NAME (Type) <b>FARANGIS KHORASANI, M.D.</b>		23D. ADDRESS <b>WILKENS &amp; CATON AVES.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-21-1972</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Wilkins Ave. Balto. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitson</b>		25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home, 4107 Wilkens Ave.</b>

501:3 AUGUST 18, 1935

525 LONGWOOD ST.  
BALTIMORE, MARYLAND 21220

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1935

CONCRETE TERRACE

ST. ANNE'S HOSPITAL  
1100 N. CALTON AVE.  
BALTIMORE, MARYLAND 21220

WHITE

HOSPITAL

JOHN 21220

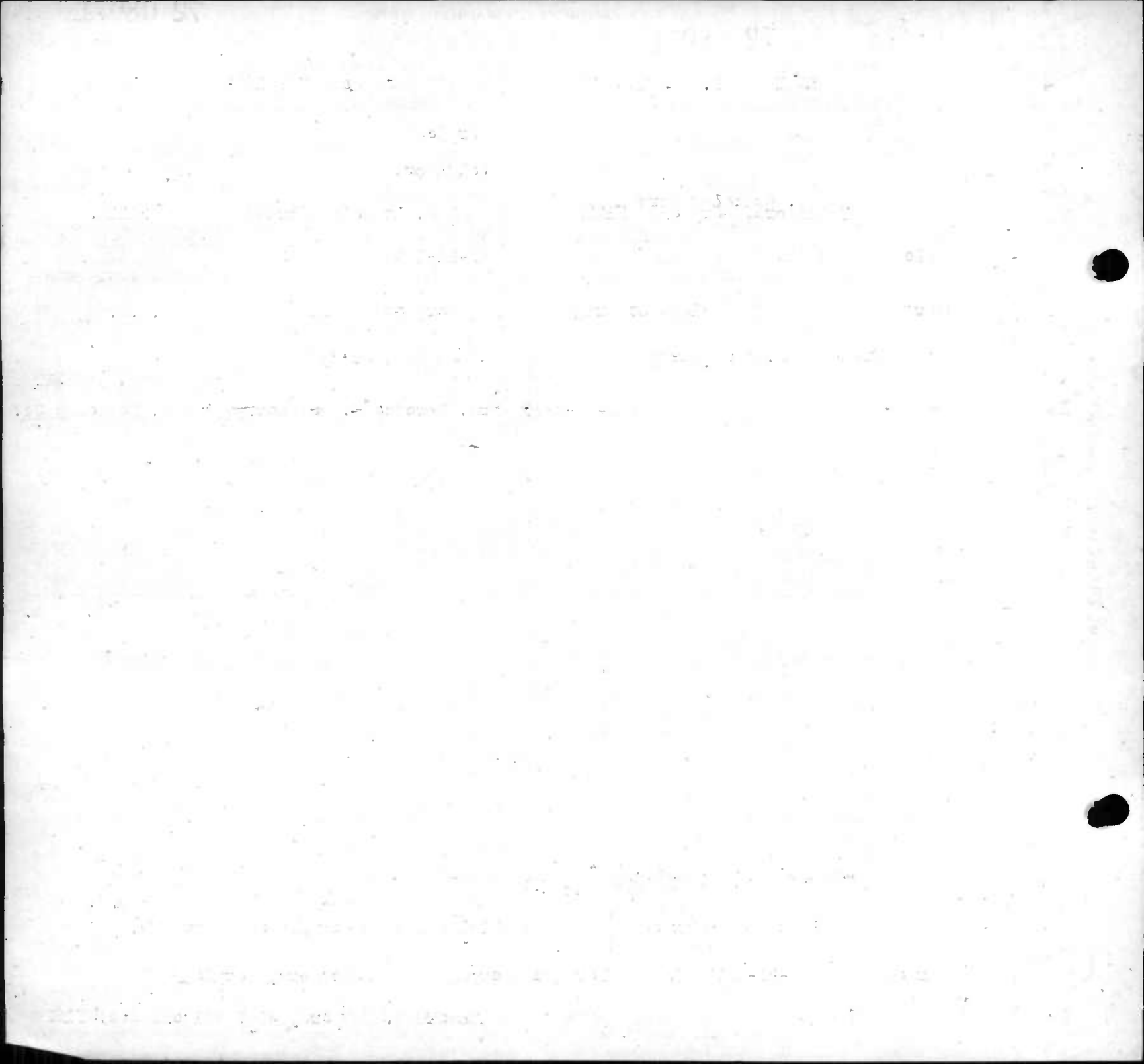
PARAMOUNT KINOGRAPH, INC., 1100 N. CALTON AVE.

11-1072 14-1072 15-1072

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 08071</span>	
D-263 72 08071				STATE OF MARYLAND - DIME	
1. NAME OF DECEASED (Type or Print) <b>LEWIS P. DAUGHERTY</b>			2. DATE AND HOUR OF DEATH <b>August 20, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 404 S. Bentalou Street Baltimore, Maryland 21223</b>			A. STATE <b>Maryland</b> B. COUNTY <b>2005</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>404 S. Bentalou Street 21223</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-21-1910</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Globe Security</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank A. Daugherty</b>			
14. MOTHER'S MAIDEN NAME <b>Annie Stump</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>217-03-1867</b>		17. INFORMANT ADDRESS <b>21223 Mrs. Loretta G. Daugherty, 404 S. Bentalou St.</b>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ca of the lungs metastasizes to the liver</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 72</b> to <b>Aug 20 72</b> , that (I) (we) last saw the deceased alive on <b>Aug 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Justin Kudirka</b> Attending Physician <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Justin Kudirka</b>				23D. ADDRESS <b>2151 Wilkens Avenue, Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-23-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Hubbard</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-420		72 08072		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08072	
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) TOWLES, ROBERT OTHELIOUS				2. DATE AND HOUR OF DEATH AUGUST 20, 1972 5:35 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21223 2006 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 29 02	
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HENRY TOWLES				14. MOTHER'S MAIDEN NAME XXXXXXXXXXXXXXXXXXXX Sidnie (Unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214106801		17. INFORMANT WILKENS AVENUES-BALTO; MD. 21229 ST AGNES HOSPITAL'S RECORDS CATON &			
18. 200.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Reticulum cell sarcoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: With metastases (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Pneumonia OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from JULY 23, 1972 to AUGUST 20, 1972, that (X) (we) last saw the deceased alive on AUGUST 20, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE Vincent H. Wang, M.D.				23B. DATE SIGNED 08 20 72		23C. PHYSICIAN'S NAME (Type) VINCENT H. WANG, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-23-1972		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

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72 08073

STATE OF MARYLAND-DEMD  
BALTIMORE CITY HEALTH DEPARTMENT.

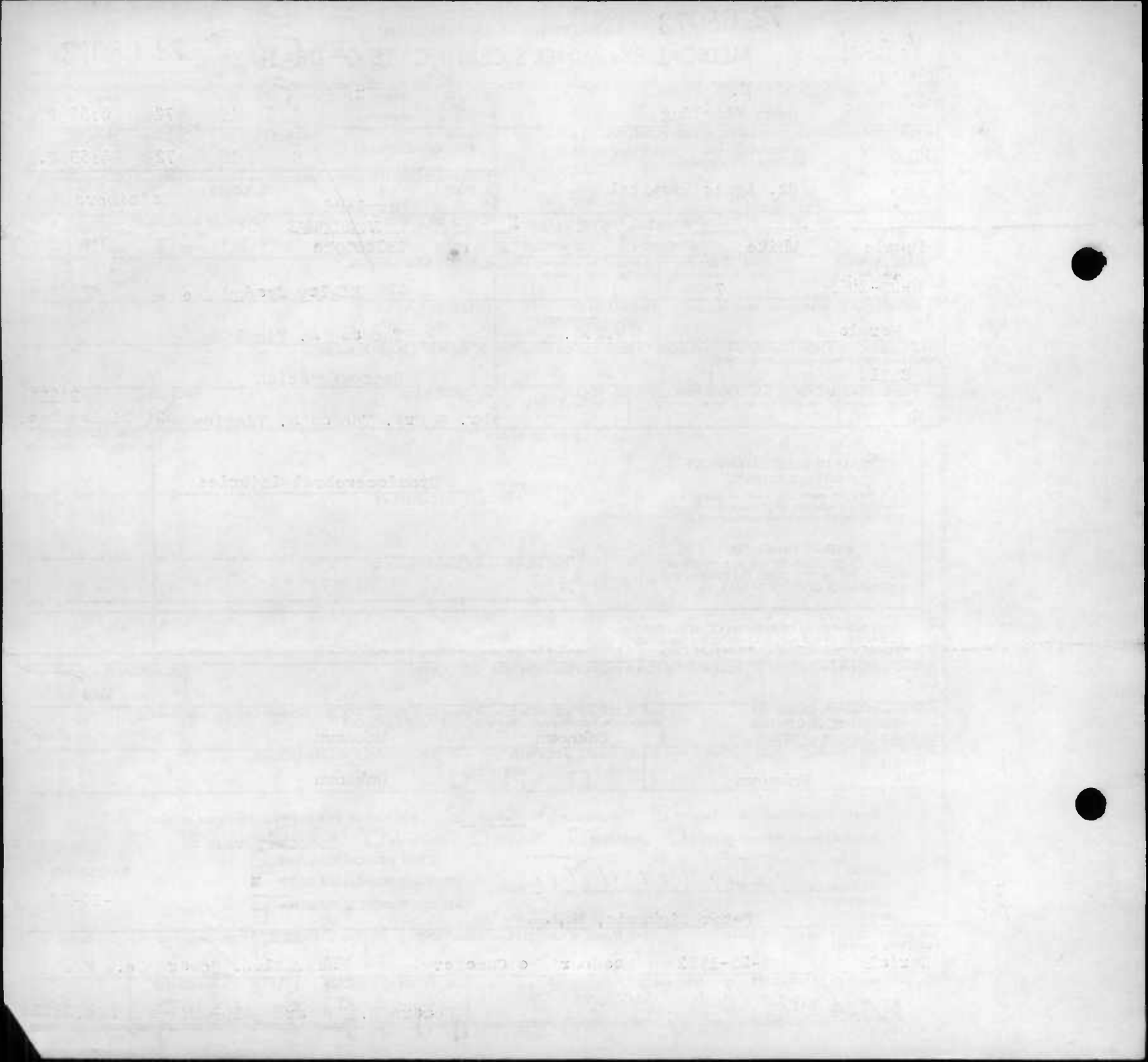
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08073

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Dawn Yingling		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 19 Year 72 Hour 4:53 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month 8 Day 19 Year 72 Hour 4:53 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH 6-23-1965		10. AGE (in years last birthday) 7	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas A. Yingling		14. MOTHER'S MAIDEN NAME Betty Stith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. & Mrs. Thomas A. Yingley		18. ADDRESS 21227 429 Bigley Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. IMMEDIATE CAUSE Craniocerebral injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
21. DATE OF OPERATION 2		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. Unknown		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	
25. TIME OF INJURY (APPROX.) Unknown		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
27. HOW DID INJURY OCCUR? Unknown		28. AUTOPSY? (Yes or No) Yes	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
30. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
32. DATE 8-23-1972		33. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery	
34. DATE REC'D BY HEALTH DEPT. AUG 24 1972		35. NAME OF REGISTRAR Sidney Johnston	
36. DATE 8-23-1972		37. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21220	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08074</b>	
BIRTH NO. <b>S-400</b>		72 08074 <b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>SCALLIO, Saverio J</b>		2. DATE AND HOUR OF DEATH <b>8-20-72</b> <b>10:55 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1803</b>	
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>09-12-09</b>	
9. AGE (In years last birthday) <b>62</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Produce Merchant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Santo Scallio</b>		14. MOTHER'S MAIDEN NAME <b>Maria Balsano</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 5-8-42 to 11-14-44</b>		16. SOCIAL SECURITY NO. <b>214-16-6272</b>	
17. INFORMANT <b>VA Hospital Records</b>		ADDRESS <b>Baltimore, Maryland 21218</b>	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac tamponade</b>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pericardial effusion</b>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Secondary to Ca of lung</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 Days</b>          <b>Years</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 31, 1972</b> to <b>August 20, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 20, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.			
23A. SIGNATURE <b>Thomas E. Murphy, M.D.</b>		23B. DATE SIGNED <b>8-21-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas E. Murphy, M. D.</b>		23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-24-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>	

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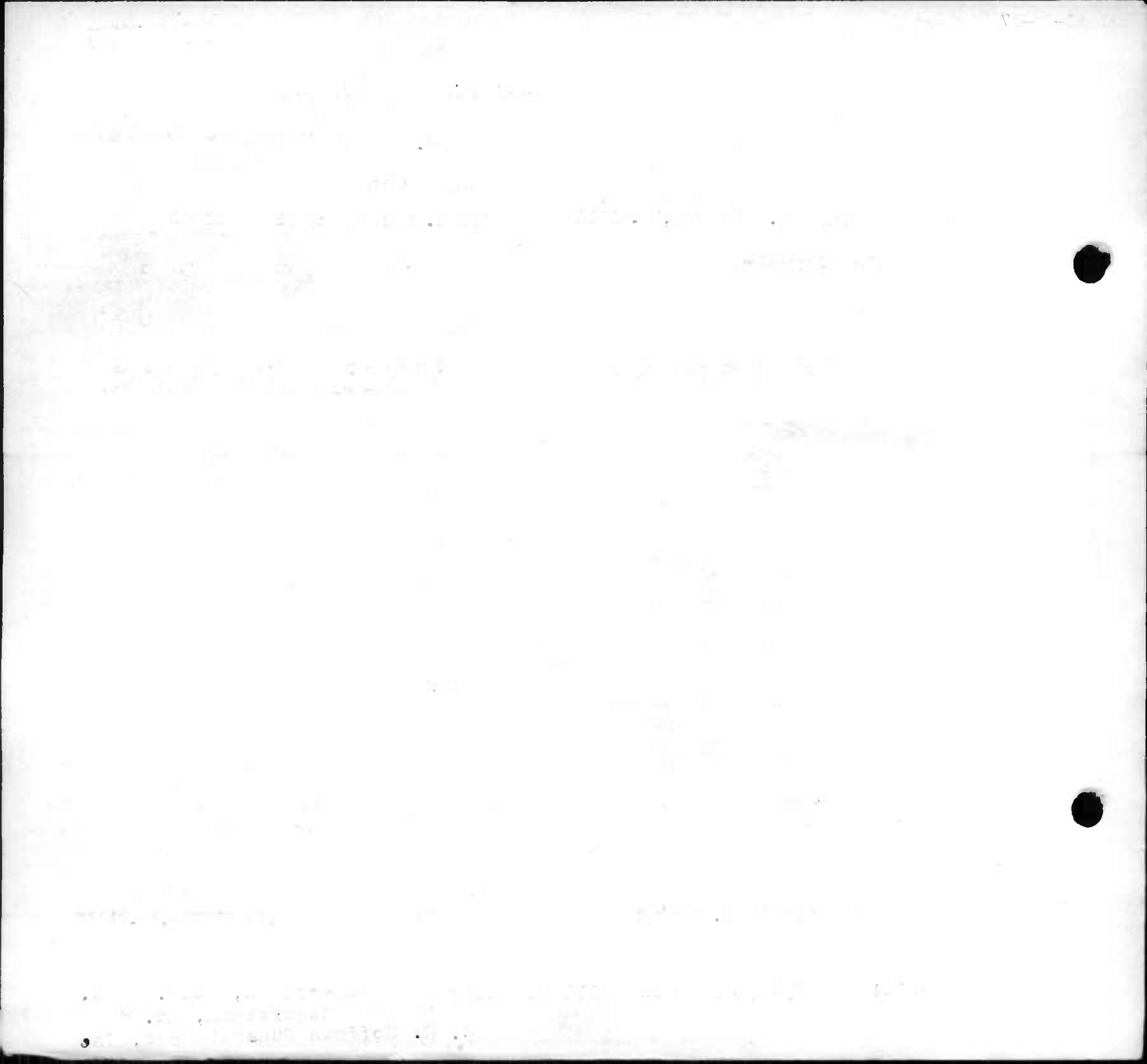
10:00

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 72 08075		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. Washington Co. Md.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) THOMAS, BABY GIRL -Deborah		2. DATE AND HOUR OF DEATH 8/20/72 3:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSP. INTENSIVE CARD NURSERY 4940 Eastern Ave. Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY BORN AT HAGERSTOWN, MD Washington C. CITY OR TOWN D. INSIDE CITY LIMITS? Hagerstown YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 319 S. Locust Street 21740 7103	
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —	9. AGE (in years last birthday) 0
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NO RECORD		14. MOTHER'S MAIDEN NAME THOMAS DEBORAH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT JOSEPH T. MARINO		18. ADDRESS BCH-Records-4940 Eastern Ave. BALTIMORE MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 778.21 CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIORESPIRATORY ARREST 15 MIN (B) HEMORRAGE DUE TO, OR AS A CONSEQUENCE OF: 2 DAYS (C) COAGULOPATHY 2 DAYS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). BREECH DELIVERY, PREMATURITY		20A. AUTOPSY? (Yes or No) Yes	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (A) (this hospital) attended the deceased from 8/18 1972 to 8/20 1972 that (A) (we) last saw the deceased alive on 8/20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Joseph T. Marino		23B. DATE SIGNED 8/20/72	
23C. PHYSICIAN'S NAME (Type) JOSEPH T. MARINO		23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/22/72	
24C. NAME OF CEMETERY or CREMATORY Rose Hill Cemetery		24D. LOCATION (City, town, or county) (State) Hagerstown, Wash. Md.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR A. K. Coffman	
25C. FUNERAL DIRECTOR A. K. Coffman		25D. ADDRESS Funeral Home, Inc.	



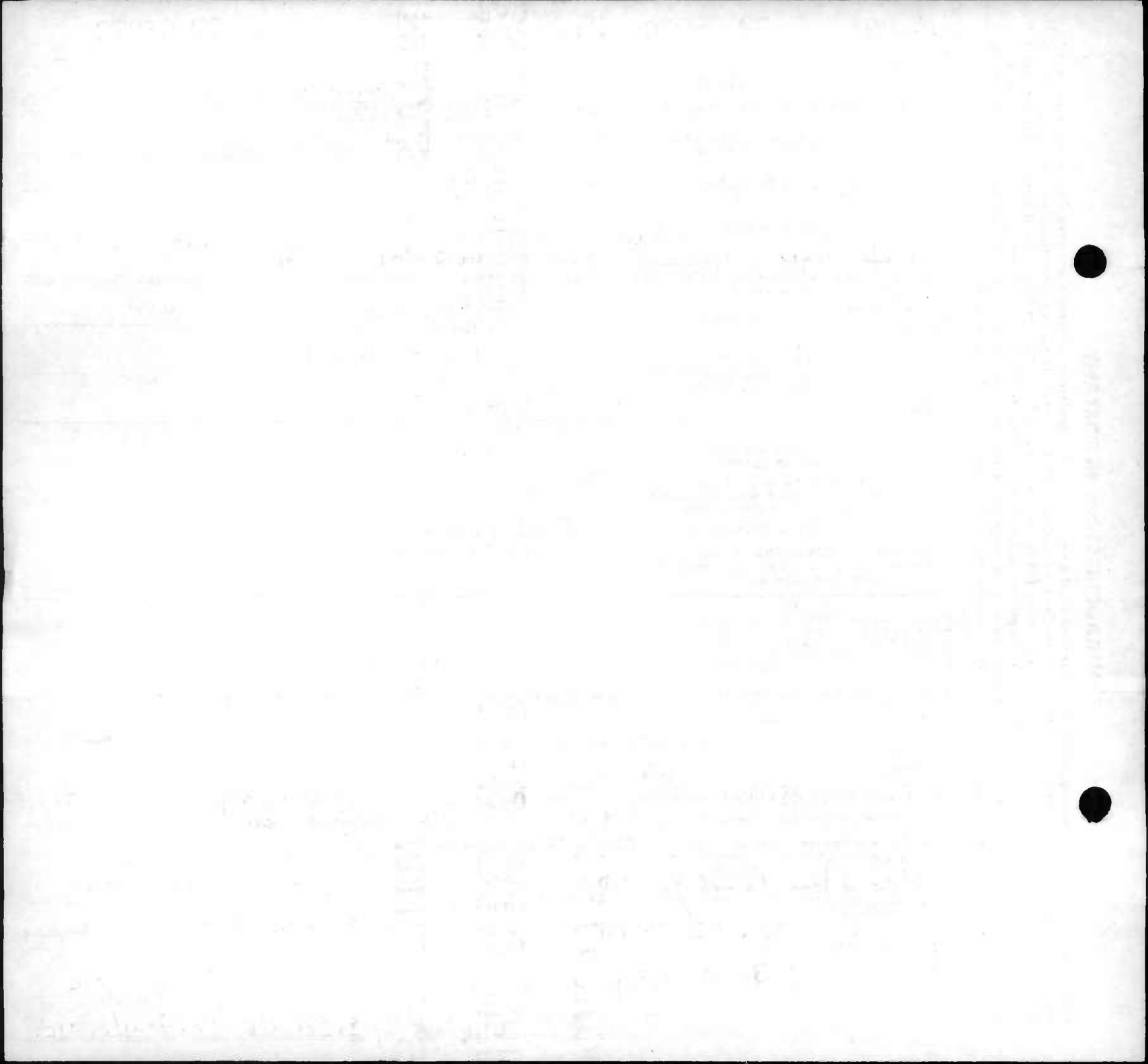


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

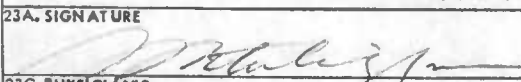
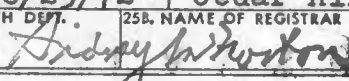
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08076	
72 08076				STATE OF MARYLAND-DMH	
BIRTH NO. <u>H-400</u>		1. NAME OF DECEASED (Type or Print) <u>Clarence Hall</u>			
2. DATE AND HOUR OF DEATH <u>August 18, 1972</u> <u>303</u> <u>P</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u> <u>33</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Owings</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5. STREET AND NUMBER <u>Box 138 RR 262</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06/24/01</u>	9. AGE (In years last birthday) <u>71</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Hubber Hall</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Holland</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-9318A Chart</u>		17. INFORMANT ADDRESS	
18. <u>593.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u>		CAUSE OF DEATH <u>Respiratory failure 2° pulmonary edema</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Inotify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(myself)</u> attended the deceased from <u>Aug 3</u> 19 <u>72</u> to <u>Aug 18</u> 19 <u>72</u> that (I) <u>(myself)</u> last saw the deceased alive on <u>Aug 18</u> 19 <u>72</u> and that in (my) <u>(myself)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(myself)</u> (did) <u>(not)</u> view the body after death.					
23A. SIGNATURE <u>Edward James Busick Jr. M.D.</u>		23B. DATE SIGNED <u>Aug 18, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>DR EDWARD JAMES BUSICK</u>	
23D. ADDRESS <u>Box 905 1620 N. Elden St Baltimore, Maryland</u>		24A. (BURIAL) CREMATION, REMOVAL (Specify) <u>8-23-72</u>			
24B. DATE <u>8-23-72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. Hope Chr. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Calvert Co., Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 21 1972</u>		25B. NAME OF REGISTRAR <u>William J. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Pinkey E. Sewell Pr. Fred., Md.</u>	





# FUNERAL DIRECTOR: IMPORTANT

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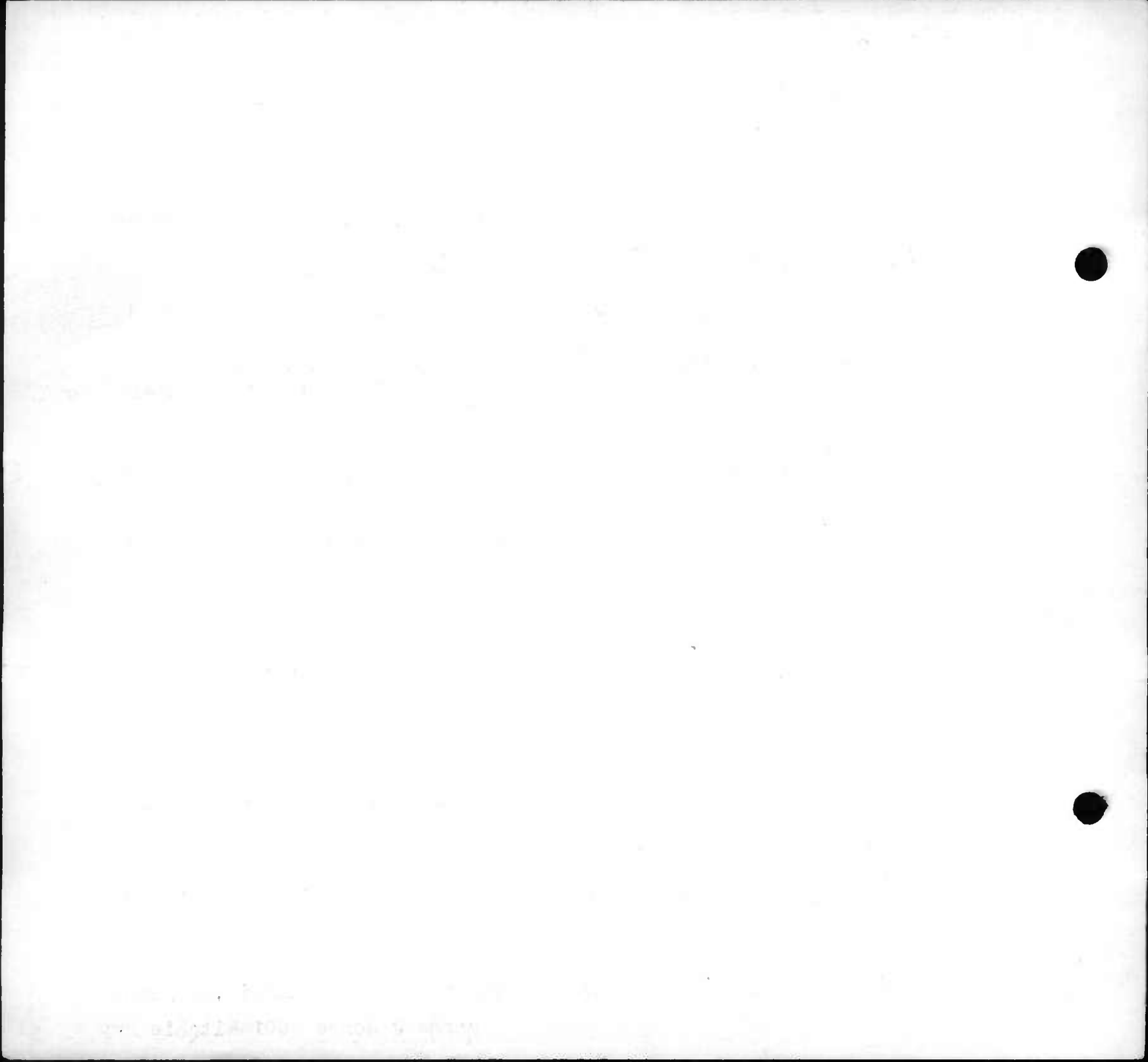
BALTIMORE CITY HEALTH DEPARTMENT				72 08077		72 08077	
P-320				72 08077		72 08077	
BIRTH NO.				72 08077		72 08077	
1. NAME OF DECEASED (Type or Print) <b>BERTHA H. POTTS</b>				2. DATE AND HOUR OF DEATH <b>8/19/72 10:20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>S. BALTIMORE GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2505</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3701 PASCAL AVE.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-7-1899</b>		9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE Seamstress</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>HOLDEN</b>			14. MOTHER'S MAIDEN NAME <b>Mary Booker</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>212 10 4970</b>		17. INFORMANT ADDRESS <b>Alma Youngbar 3701. Pascal Ave 21226</b>		
18. <b>5/11/21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>TERMINAL PNEUMONIA</b> <b>PLEURAL EFFUSION</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/17</b> 19 <b>72</b> to <b>8/19</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/19</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>DR. CALVUS N. PATALINGHUG</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/23/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A.Co, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001. Ritchie Hwy.</b>	

10/31/72 - Cause of Pleural Effusion  
unknown. Letter from  
Lutheran Hosp in file -  
Bur. of Biostatistics  
ge

# FUNERAL DIRECTOR: IMPORTANT

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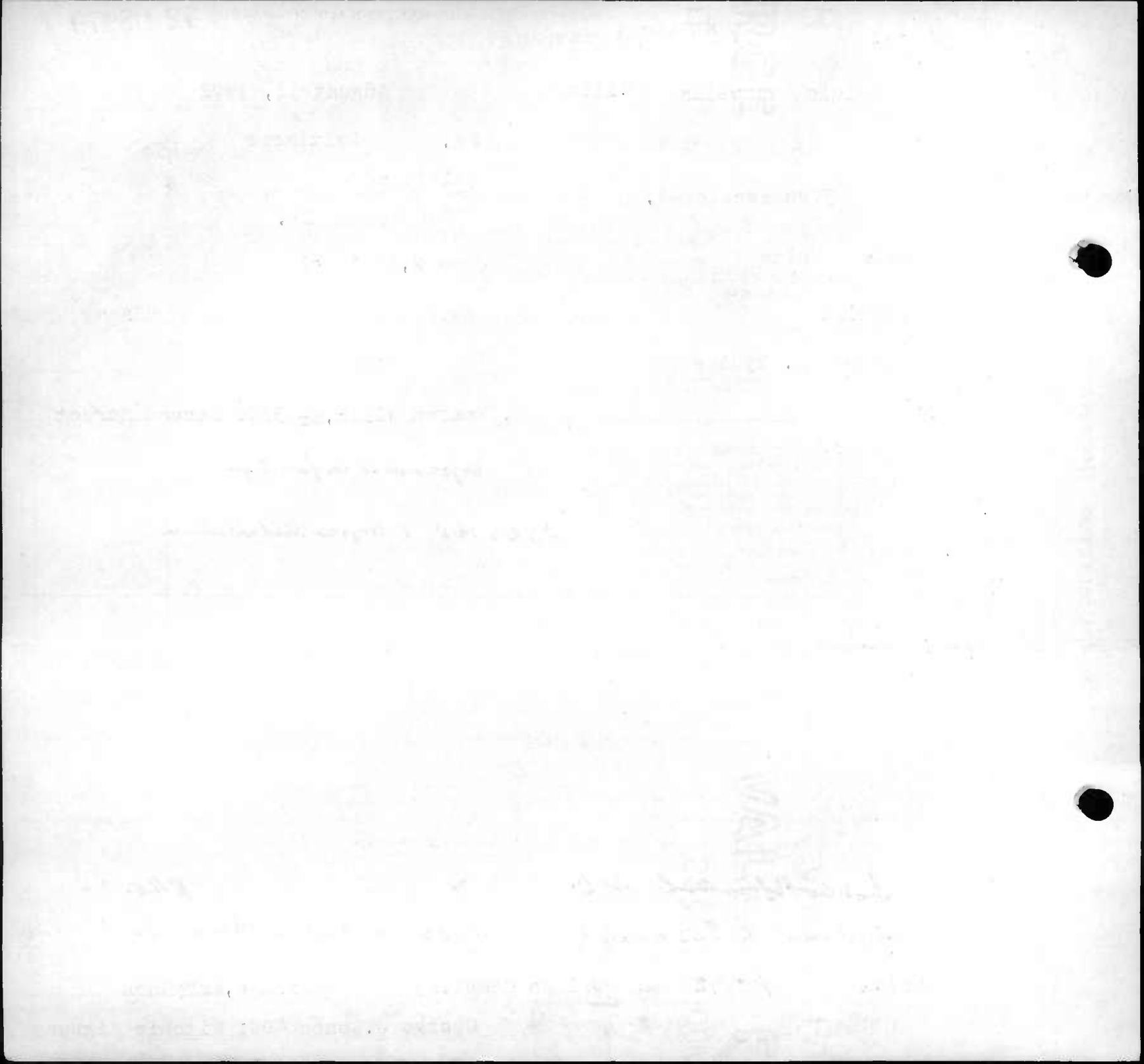
Baltimore City Health Department				72 08078		REG. NO. 72 08078	
C-616				72 08078		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SABINA O CRAWFORD</b>				2. DATE AND HOUR OF DEATH <b>8/19/72 10<sup>30</sup> P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO. AA</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSP. OF BALTO</b>				C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1138 McHENRY DR. 21061</b>							
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/19/22</b>	9. AGE (In years last birthday) <b>XXX 49</b>	10. Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Telephone Co</b>		11. BIRTHPLACE (State or foreign country) <b>? New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>? William O'Brien</b>				14. MOTHER'S MAIDEN NAME <b>? Marie Callahan</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Robert Crawford</b> ADDRESS <b>416 Chumleigh Road</b> <b>Hospital CHART</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic CARCINOMA OF BREAST 2 years</b> (B) <b>CARCINOMA OF BREAST - 1 1/2 years</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8/19/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/9/72</b> 19 to <b>8/19/72</b> 19 that (I) (we) last saw the deceased alive on <b>8/19/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert S. London, MD</b> DEGREE				23B. DATE SIGNED <b>8/19/72</b>		23C. PHYSICIAN'S NAME (Type) <b>ROBERT S. LONDON, M.D.</b> DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8/23/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION <b>Glen Burnie, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>			
25B. NAME OF REGISTRAR <b>George J Gonce</b>				25C. FUNERAL DIRECTOR <b>4001 Ritchie Hwy</b>			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 08079		72 08079	
W-420				72 08079		72 08079	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <b>Goldie Carvella Wills</b>				2. DATE AND HOUR OF DEATH <b>August 18, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 3706 Second St.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3706 Second St.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1891</b>		9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George M. Tydings</b>				14. MOTHER'S MAIDEN NAME <b>Jennie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Warren Wills, Sr 3706 Second Street</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCUTD = Myocardial Ischemia</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Andrew R. Sosnowski MD</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8/18/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Andrew R. Sosnowski</b>				23D. ADDRESS <b>4016 Ritchie Hwy Balto 25 Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/21/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Elkridge, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>				25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Highway</b>	

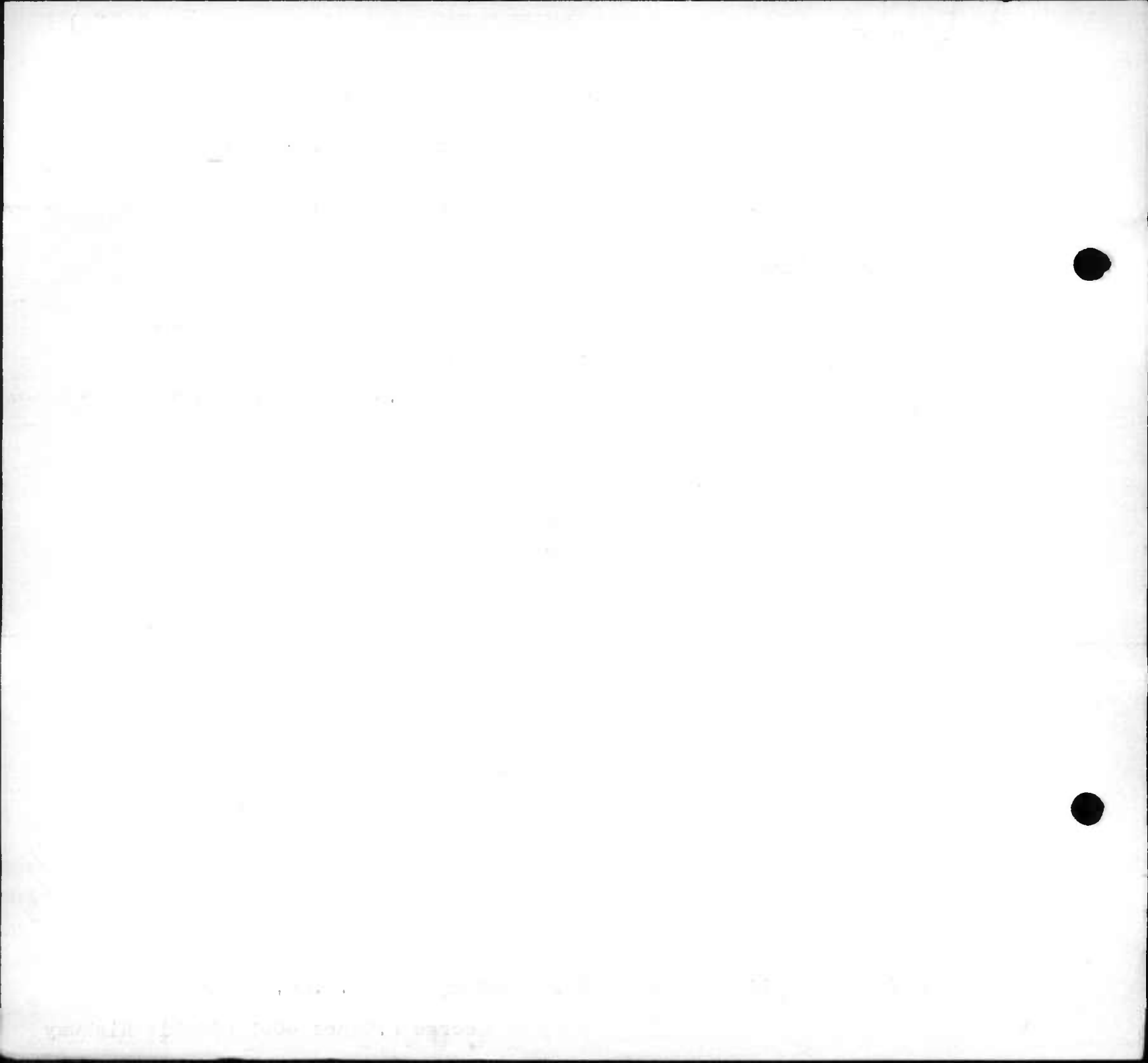




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

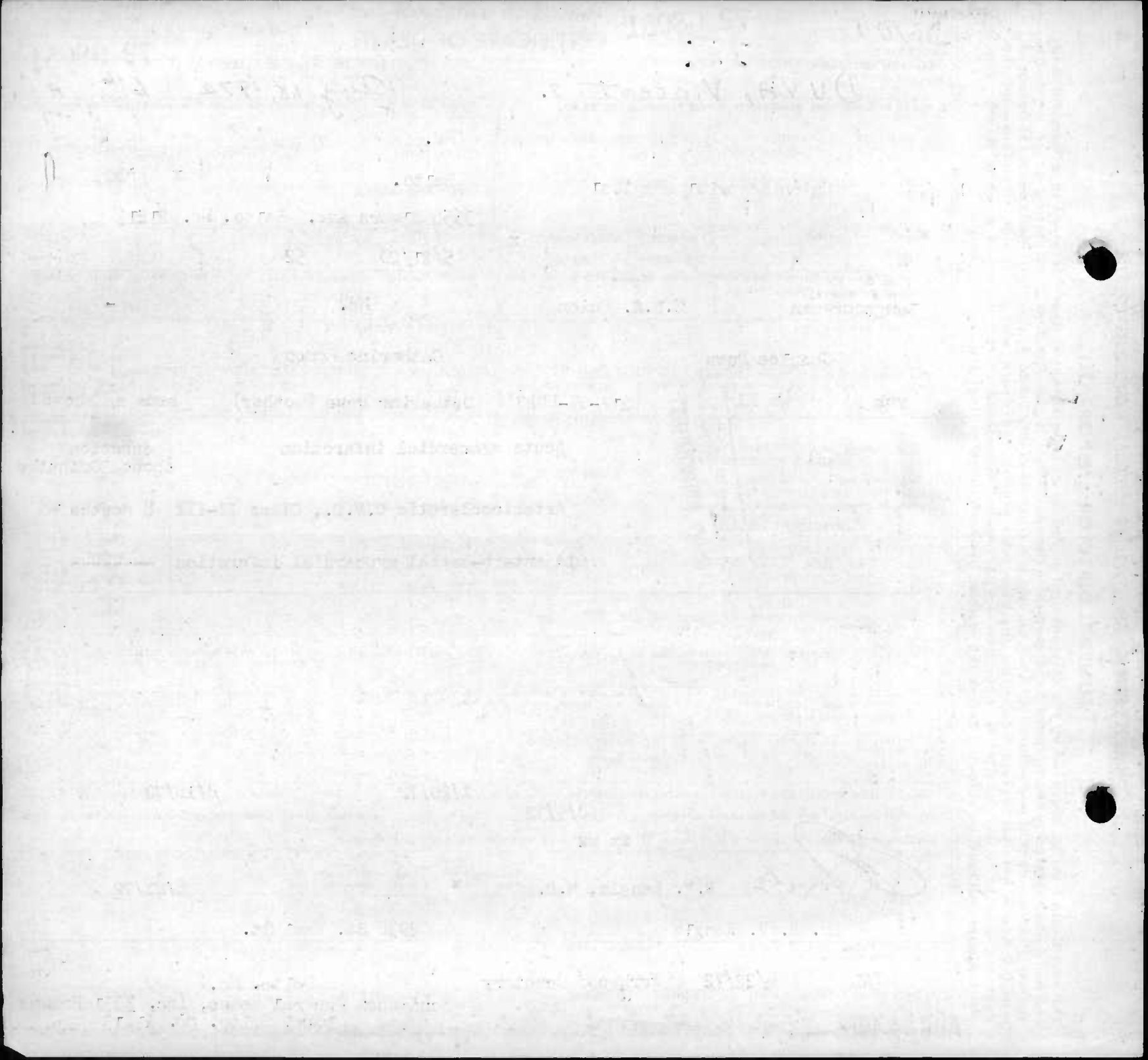
BALTIMORE CITY HEALTH DEPARTMENT				72 08080		72 08080	
J-525				72 08080		72 08080	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>JENKINS EVA Ray</b>				2. DATE AND HOUR OF DEATH <b>8-18-72 2:45 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Balt. Gen. Hosp.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>43</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>2001 Annapolis St. 21230</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-07</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>David Davis (Dea)</b>			14. MOTHER'S MAIDEN NAME <b>Lizette</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>216-5-8719-B</b>		17. INFORMANT <b>Thomas T. Jenkins 336 Maude Avenue</b>		
			18. CAUSE OF DEATH <b>2001 I</b>		ADDRESS <b>336 Maude Avenue</b>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Terminal Ca, Generalized</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Symptomatic cancer probable</b> DUE TO, OR AS A CONSEQUENCE OF:				
			(C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (if this hospital) attended the deceased from <b>8-15</b> 19 <b>72</b> to <b>8-18</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8-18-72</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>8-18-72 (2:45 AM)</b>							
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED <b>8-18-72 (3:00 PM)</b>			
23C. PHYSICIAN'S NAME (Type) <b>B. Carlos M. Patolinghug</b>				23D. ADDRESS <b>SBGA 3001 Annapolis St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/21/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A.Co, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Lidney [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonca 4001 Ritchie Highway</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. STATE OF MARYLAND	
D-100 72 08081				72 08081	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)	
				DUVA, Vincent F.	
2. DATE AND HOUR OF DEATH				Aug. 18 1972 6:16 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
44 Union Memorial Hospital				Md. 2643	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday)	
M W				5/21/20 52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
Longshoreman				Md.	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
I.L.A. Union				-	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Charles Duva				Catherine Romeo	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
yes WW II				217-07-8847	
17. INFORMANT				ADDRESS	
Catherine Duva (mother)				same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Acute myocardial infarction				duration	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				about 30 minutes	
Arteriosclerotic C.V.D., Class II-III				8 months +	
(B) DUE TO, OR AS A CONSEQUENCE OF:				-----	
Old antero-septal myocardial infarction				-----	
(C) -----				-----	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/20/72 19 to 8/18/72 19, that (I) (we) last saw the deceased alive on 8/5/72 19 and that in (my) (our) opinion death occurred on the date and hour <del>and</del> from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
R.V. Rangle, M.D.				8/21/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. R. V. Rangle				2938 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
BURIAL				8/22/72	
24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town, or county) (State)	
Parkwood Cemetery				Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
AUG 24 1972 Sidney Johnston					
25C. FUNERAL DIRECTOR				ADDRESS	
Schimunek Funeral Homes, Inc.				3331 Brehms Lane, Balto. Md. 21213	



72 08082

STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08082  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN E. MILLER</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 18 72 7:50 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5119 Wright Ave.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 18 72 7:50 P.M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7/28/00				10. AGE (in years lost birthday) 71		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert Miller		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2634	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance agent				16. KIND OF BUSINESS OR INDUSTRY United Life of America			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) no				18. SOCIAL SECURITY NO. 215-05-8547		19. INFORMANT Violet Miller (wife)	
20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				21. IMMEDIATE CAUSE (A) IMMEDIATE CAUSE Arteriosclerotic Cardiovascular DUE TO, OR AS A CONSEQUENCE OF: Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
22A. DATE OF OPERATION				23. CONDITION FOR WHICH OPERATION WAS PERFORMED			
24A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home			
26. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				28. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 29. HOW DID INJURY OCCUR?			
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8/23/72			
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery				24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972				25B. NAME OF REGISTRAR Adney Whitson			
25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brooks Lane, Balto. Md. 21213				25D. ADDRESS			

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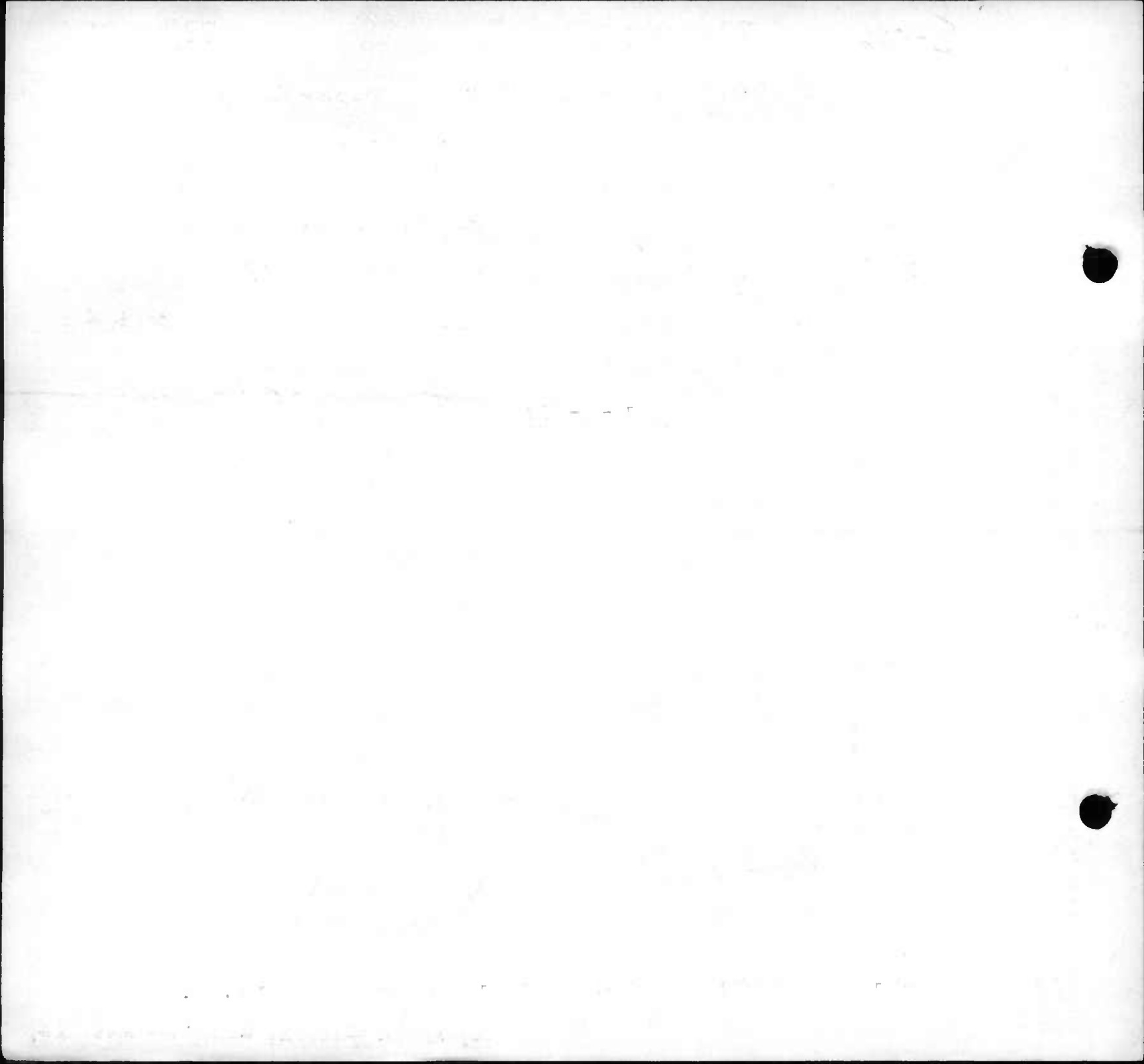


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-526		72 08083		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08083	
<b>CERTIFICATE OF DEATH</b>							
BIRTH NO.		STATE OF MARYLAND-DHMH					
1. NAME OF DECEASED (Type or Print)		SENGER, ANTONIE Barbara				2. DATE AND HOUR OF DEATH 8-20-72, 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND				B. COUNTY 702	
CHURCH HOME & HOSPITAL 35		C. CITY OR TOWN BALTIMORE CITY				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 820 N. GLOVER STREET					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04-12-85		9. AGE (In years last birthday) 87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) CZECH		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH LORECA				14. MOTHER'S MAIDEN NAME Barbara?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 212-74-9432		17. INFORMANT Helen Manson		ADDRESS 3382 Juneway	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 42201				Congestive Heart Failure, Pleural Effusion, Rt., Renal failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-4-1972 to 8-20-1972 that (I) (we) lost saw the deceased alive on 8-20-1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jung H. Kim, M.D.				23B. DATE SIGNED 8-20-72		23C. PHYSICIAN'S NAME (Type) MORRISON, KIM, JUNG-HO, M.D.	
23D. ADDRESS CHURCH HOME & HOSP. BALTIMORE, MD				23E. DATE REC'D BY HEALTH DEPT. AUG 24 1972			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/23/72		Bohemian National Cemetery		Balto. Md.	
25A. NAME OF REGISTRAR Andrew H. ...		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SALIMANEK Funeral Home		ADDRESS 3331 BETHENS LA.	

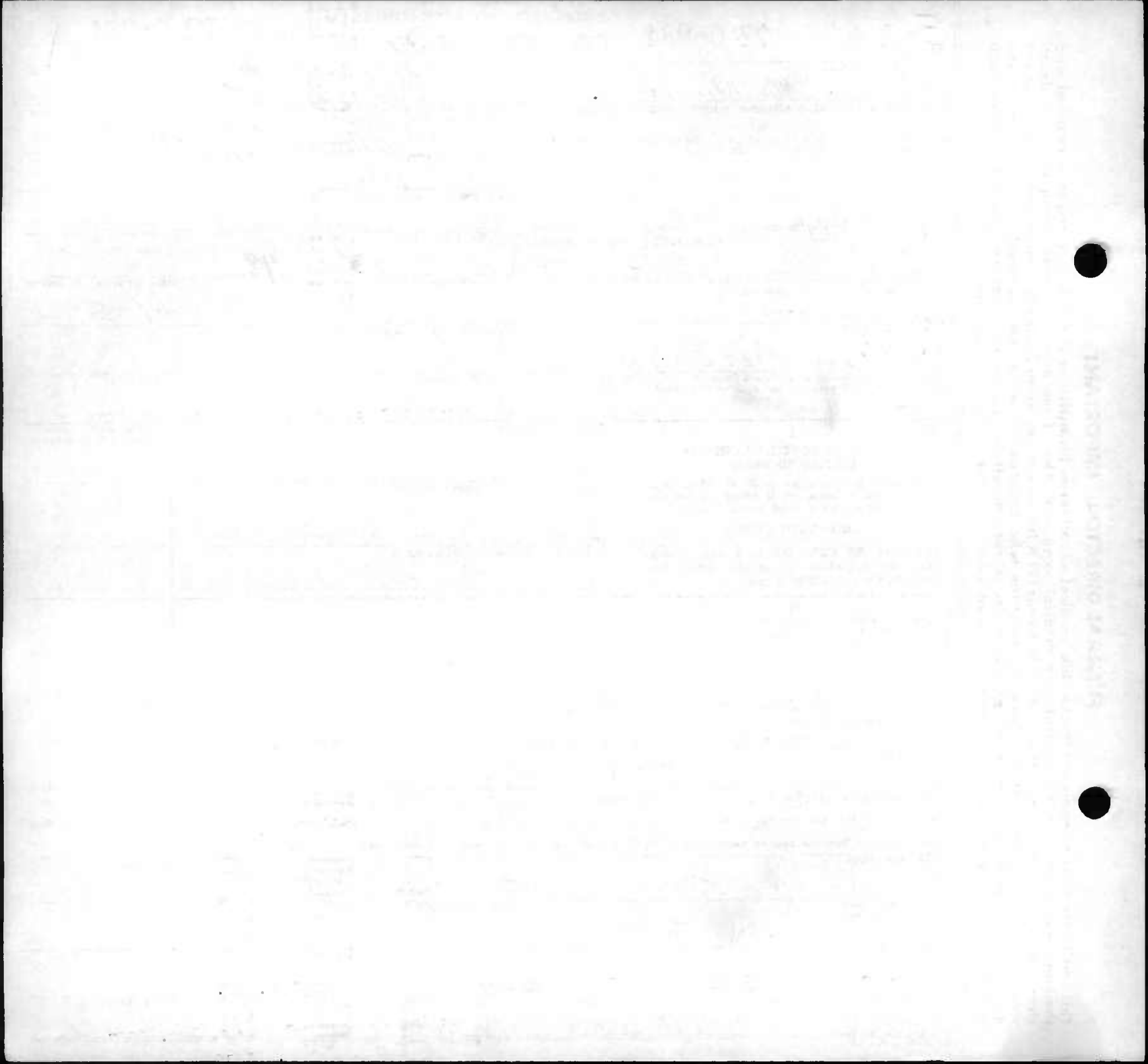




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

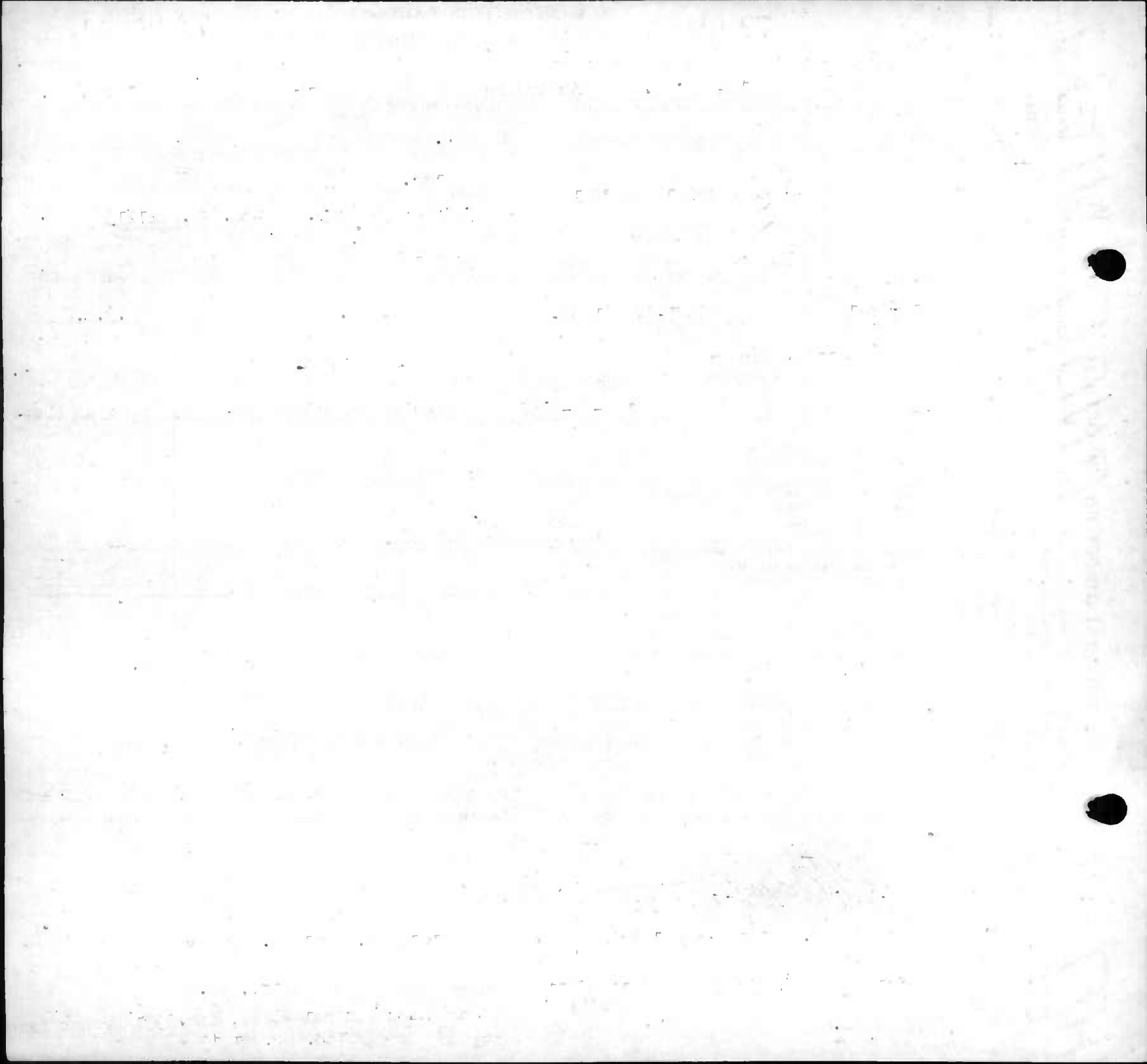
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 08084</span>	
E-534 <span style="font-size: 1.2em;">72 08084</span>				CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) <u>Endlich, Mrs. Minnie H.</u>			2. DATE AND HOUR OF DEATH <u>8/20/72 8:10 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hosp.</u>			A. STATE <u>Ba 1 to</u> B. COUNTY <u>Ba 1 to</u> C. CITY OR TOWN <u>Ba 1 to</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>437 N. Ellwood Ave</u> <u>601</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-93</u>		9. AGE (in years last birthday) <u>78</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>William Meibohn</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (if yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>216-01-0982</u>		17. INFORMANT <u>Henry Endlich (son)</u> ADDRESS <u>same as above</u>
18. <u>401X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>dehydration Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>hypertension arteriosclerosis</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 19</u> 19 <u>72</u> to <u>Aug 20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. J. Ahn</u>				23B. DATE SIGNED <u>Aug 20 '72</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHOON Ja Ahn</u>				23D. ADDRESS <u>Bon Secours hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/23/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. LOCATION (State) <u>Balto. Md.</u>		24F. LOCATION (City, town, or county) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 24 1972</u>		25B. NAME OF REGISTRAR <u>Adolphus...</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>	
25D. ADDRESS <u>3331 Brecht Lane, Balto. 21213</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 08085</span>	
BIRTH NO. <span style="font-size: 1.2em;">R-263</span>				72 08085	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DUMM	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Thelma E. Richardson</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">8/18 12:30 P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">44 Union Memorial Hospital</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">2643</span>		
			C. CITY OR TOWN <span style="font-size: 1.2em;">Balto.</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.2em;">3929 Kenyon Ave. Balto. Md. 21213</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3/23/15</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">57</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">clerical</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Sinclair Oil Co.</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Penna.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">William Warner</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Emma Shirk</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">188-07-0559</span>	17. INFORMANT <span style="font-size: 1.2em;">Francis Richardson (husband)</span>		ADDRESS <span style="font-size: 1.2em;">same as above</span>
18. <span style="font-size: 1.2em;">412.3 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.2em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Cause prior to death</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="font-size: 1.2em;">AS H Dis</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">7-31-72</span> 1972 to <span style="font-size: 1.2em;">8-18-72</span> 1972, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">8-18-72</span> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">8-22-72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. Julius Waghelstein</span>				23D. ADDRESS <span style="font-size: 1.2em;">1010 St. Paul St.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">8/23/72</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holly Hill Cemetery</span>	
24D. LOCATION <span style="font-size: 1.2em;">Balto. Md.</span>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">AUG 24 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">[Signature]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimunek Funeral Homes, Inc. 3331 Brehms Lane Balto. Md. 21213</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-550		72 08086		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08086	
BIRTH NO.		72 08086		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) CLARA U. THOMAN				2. DATE AND HOUR OF DEATH 08-21-72 9.05 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland Baltimore 2733			
5. SEX F. 6. RACE W. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 03-31-17		9. AGE (In years, last birthday) 54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William E. Miller				14. MOTHER'S MAIDEN NAME Myra Griffin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no				16. SOCIAL SECURITY NO. 218-09-0899		17. INFORMANT William A. Thoman, Same as Above	
18. I <u>436.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory Arrest (B) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hr. 14 days.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 08-07-1972 to 08-21-1972 that (I) (we) last saw the deceased alive on 08-21-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dante Manyari M.D.				23B. DATE SIGNED 08-21-72		23C. PHYSICIAN'S NAME (Type) DANTE MANYARI M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/24/72		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR Andrew W. Gordon		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto., Md.		ADDRESS	

40

1940-1941

1940-1941

1940-1941



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08087
72 08087 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH
CHARLES A. POLE		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		August 21, 1972 11 P M.
00 6004 Edna Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		2745
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 6004 Edna Ave.		
5. SEX male	6. RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 8, 1891	9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital worker Fisher Body--retired		10B. KIND OF BUSINESS OR INDUSTRY Balto, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-8602	17. INFORMANT Mrs. Julia F. Pole (wife) same add.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary occlusion 1 hr (B) ASCVD & cardiac arrhythmia 15 yr DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-25-72 to 8-21-72 that (I) (we) lost saw the deceased alive on 8-25-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Richard R. von Rigler		23B. DATE SIGNED 8-22-72		
23C. PHYSICIAN'S NAME (Type) Dr. Richard R. von Rigler		23D. ADDRESS 1 W. Overlea Ave, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Aug. 24 '72	24C. NAME of CEMETERY or CREMATORY Loudon Park	24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR Sidney H. Horton		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.-Balto, Md.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08088

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Bernard Driver</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>8</b> Day <b>23</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>23</b> Year <b>72</b> Hour <b>7:45 a.</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>806</b>			
6. SEX <b>male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Mar 19, 1927</b>		10. AGE (In years last birthday) <b>45</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Driver</b>		14. MOTHER'S MAIDEN NAME <b>Irene Gordon</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) If yes give war or dates of service <b>yes KOREAN 9-20-50 to 9-25-52</b>		18. SOCIAL SECURITY NO. <b>219-18-6075</b>	
19. CAUSE OF DEATH <b>Cirrhosis of liver</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION <b>2</b>	
21. AUTOPSY? (Yes or No) <b>yes</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
25. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
27. HOW DID INJURY OCCUR?			
28. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
29. ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
31. DATE SIGNED <b>8/23/72</b>			
32. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		33. NAME OF REGISTRAR <b>Sidney W. Jones, Jr.</b>	
34. FUNERAL DIRECTOR <b>Marshall W. Jones, Jr.</b>			
35. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		36. DATE <b>8-26-72</b>	
37. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		38. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	

15-00000

1907 E. 10th Avenue

Mar 10, 1907

Henry Driver

U.S.A.

Washington, Maryland

James Gordon

General Motors

Laborer

1907 E. 10th Avenue

219-18-8075

219-18-8075

219-18-8075

Washington, D.C.

*Handwritten signature*

Washington, Maryland

1907 E. 10th Avenue

219-18-8075

219-18-8075

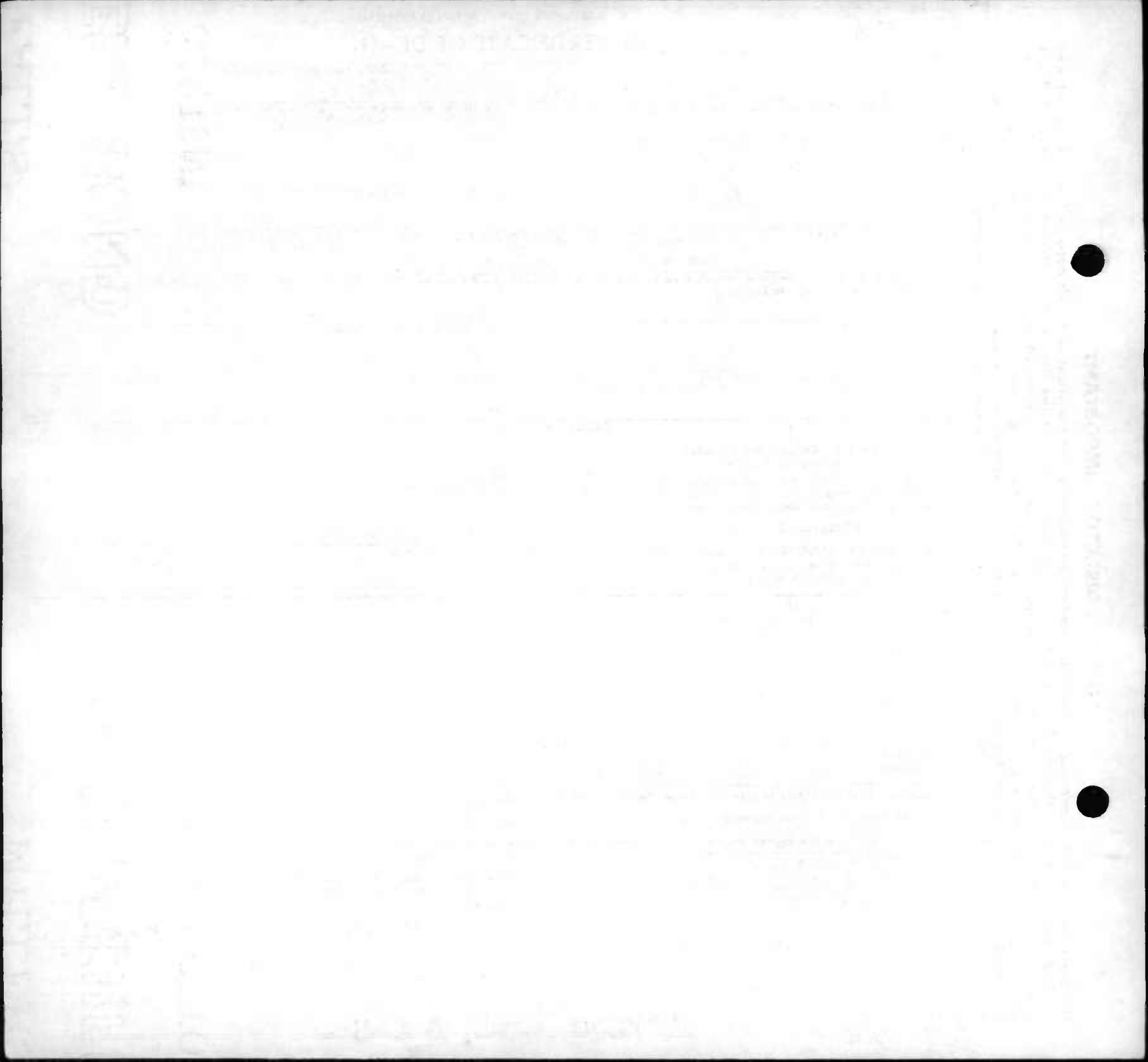
1907 E. 10th Avenue

Washington, D.C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08089</u>
T-512 <u>21252572 08089</u> <b>CERTIFICATE OF DEATH</b>				STATE OF MARYLAND-DMH
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL THOMPSON</u>		2. DATE AND HOUR OF DEATH <u>8/19/72</u> <u>7:19 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u> <u>37</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>2505</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>3911 PASCAL AVE.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/72</u>	9. AGE (In years last birthday) <u>12</u> <u>39</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>ELMER THOMPSON</u>		
14. MOTHER'S MAIDEN NAME <u>JERRI LYNN NAGI</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>J. A. SANTOS, MD.</u>		
18. <u>776.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>		ADDRESS <u>MERCY HOSPITAL</u>		
19. <u>776.9 I</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u>		
20. <u>776.9 I</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS. 39 MIN.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>8/19/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/19 (6:40 AM)</u> 19 <u>72</u> to <u>8/19 (7:19 PM)</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/19/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>J. A. Santos, M.D.</u>				23B. DATE SIGNED <u>8/20/72</u>
23C. PHYSICIAN'S NAME (Type) <u>J. A. Santos</u>				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>
24A. BURIAL CREMATION REMOVAL (Specify) <u>CITY DISPOSAL</u>				24B. DATE <u>8/22/72</u>
24C. NAME of CEMETERY or CREMATORY <u>Anatomy Bd.</u>				24D. LOCATION (City, town, or county) (State) <u>UNIVERSITY MEDICAL SCHOOL</u>
25A. DATE REC'D. BY HEALTH DEPT. <u>AUG 24 1972</u>		25B. NAME OF REGISTRAR <u>Sidney [Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>
25D. ADDRESS				

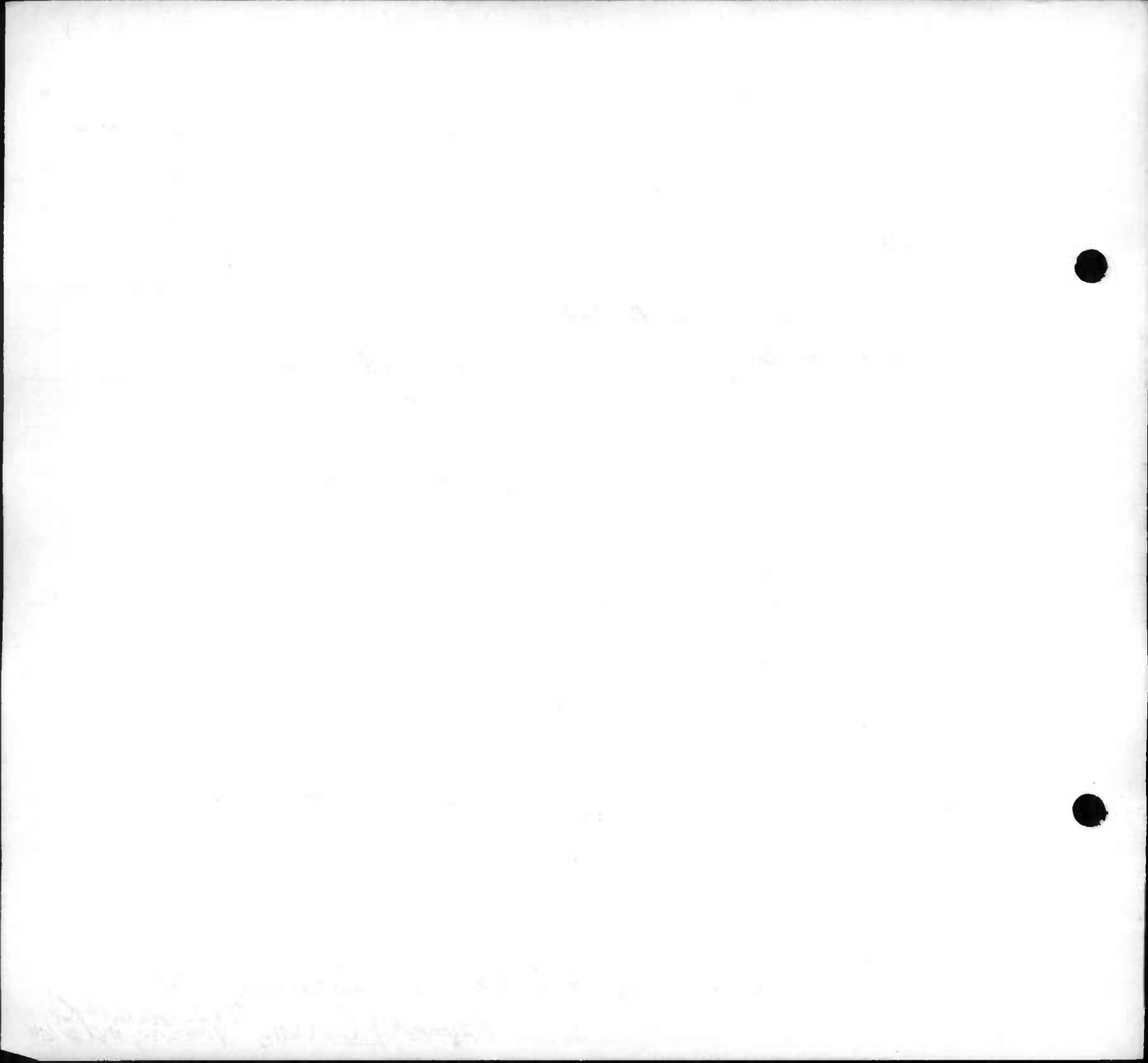


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 08090</span>	
C-534 <span style="float: right;">72 08090</span>				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JUD CHANDLER		8/11/72 3:55 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
UNIVERSITY HOSPITAL 38				MARYLAND BALTIMORE CITY	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				789 WASHINGTON BLVD 2101	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (in years last birthday)
M	W			12/17/05	67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
UNKNOWN		UNKNOWN		PENNA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
UNKNOWN				UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		217-05-5844		UNKNOWN	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				20 years	
(B) COPD DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/26/72 to 8/11/72 that (I) (we) last saw the deceased alive on 8/11/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Walt Whitman				8/11/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
WALT WHITMAN				UNIVERSITY HOSP BALTIMORE 21153	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
		8/22/72		U of M Anatomy Bldg, Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 24 1972		Sidney H. Horton		Raymond J. Curran, 8175 South Rd, Baltimore, Md 21244	



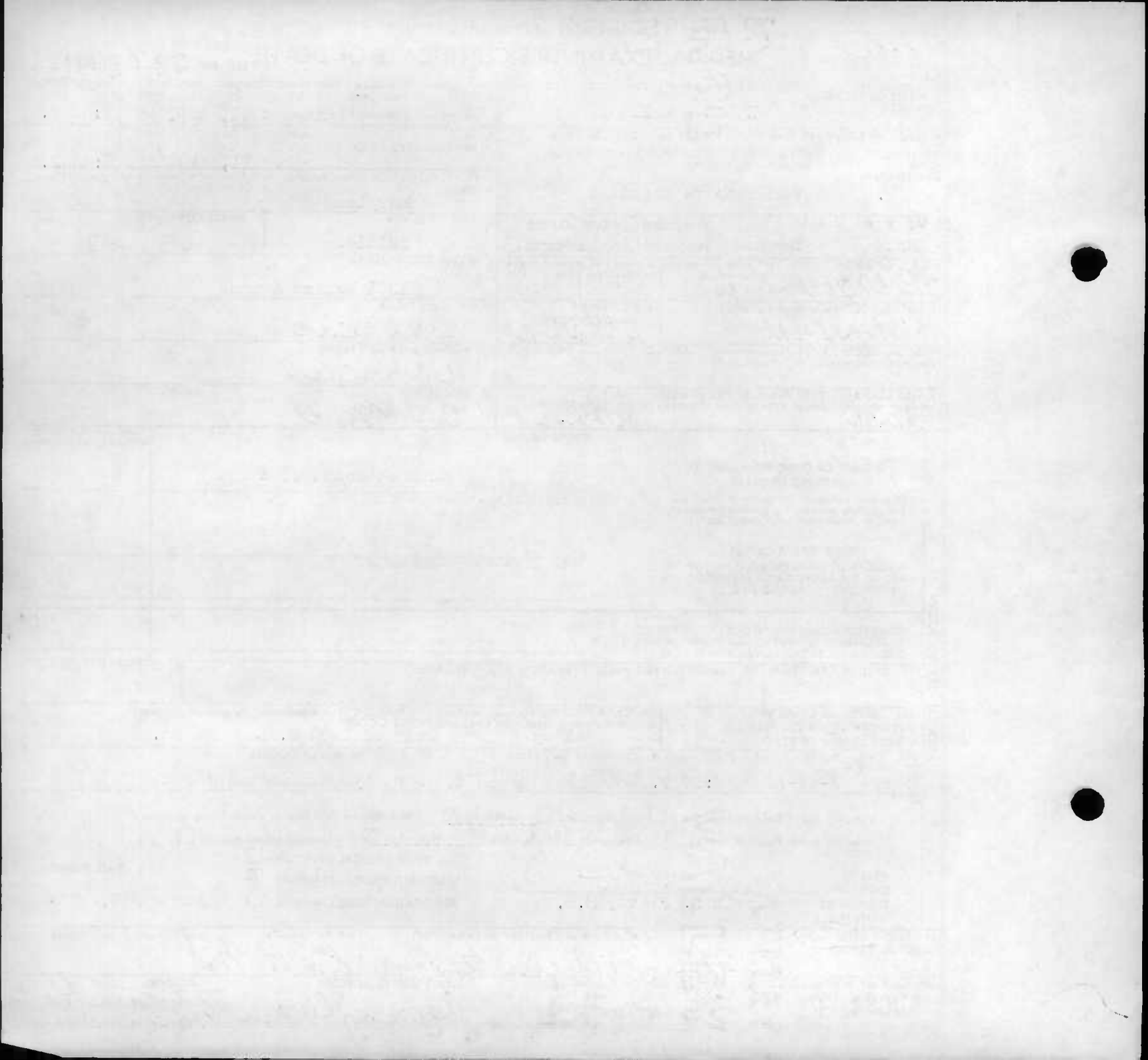


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08091

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIE SMITH</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 11, 1972</b> 6:48 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 11, 1972</b> 6:48 P.M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>UNKNOWN</b>		10. AGE (in years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNKNOWN</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. STREET AND NUMBER <b>1301 Harlam Avenue</b>	
15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		16. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1602</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		18. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. DATE OF OPERATION <b>2</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>alley</b>	
25. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>8-11-72 6:30 P.m.</b>		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>rear of 1800 W. Lanvale St.</b>		28. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>	
29. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>August 12, 1972</b>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>8-22-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>U of M. Anatomy Bldg</b>		24D. LOCATION (City, town, or county) (State) <b>Balt Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Didney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Raymond Curran</b>		25D. ADDRESS <b>817 Seaboard Ave</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Catherine Hambach		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 27 Year 72 Hour 9:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 320 N. Paca Street		3. DATE PRONOUNCED DEAD Month 7 Day 27 Year 72 Hour 9:30 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 402	
9. DATE OF BIRTH UNKNOWN		10. AGE (In years lost birthday) 70	
11. BIRTHPLACE (State or foreign country) UNKNOWN		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN	
17. SOCIAL SECURITY NO. UNKNOWN		18. INFORMANT UNKNOWN	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) William P. Mulloy, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-28-72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL (CREMATION) REMOVAL (Specify)		24B. DATE 8-22-72	
24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF M. B. AGT, MD		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. AUG 24 1972		25B. NAME OF REGISTRAR Sidney Johnson	
25C. FUNERAL DIRECTOR Raymond Curran		25D. ADDRESS 317 S. Gay St. Baltimore, Md	

100-105

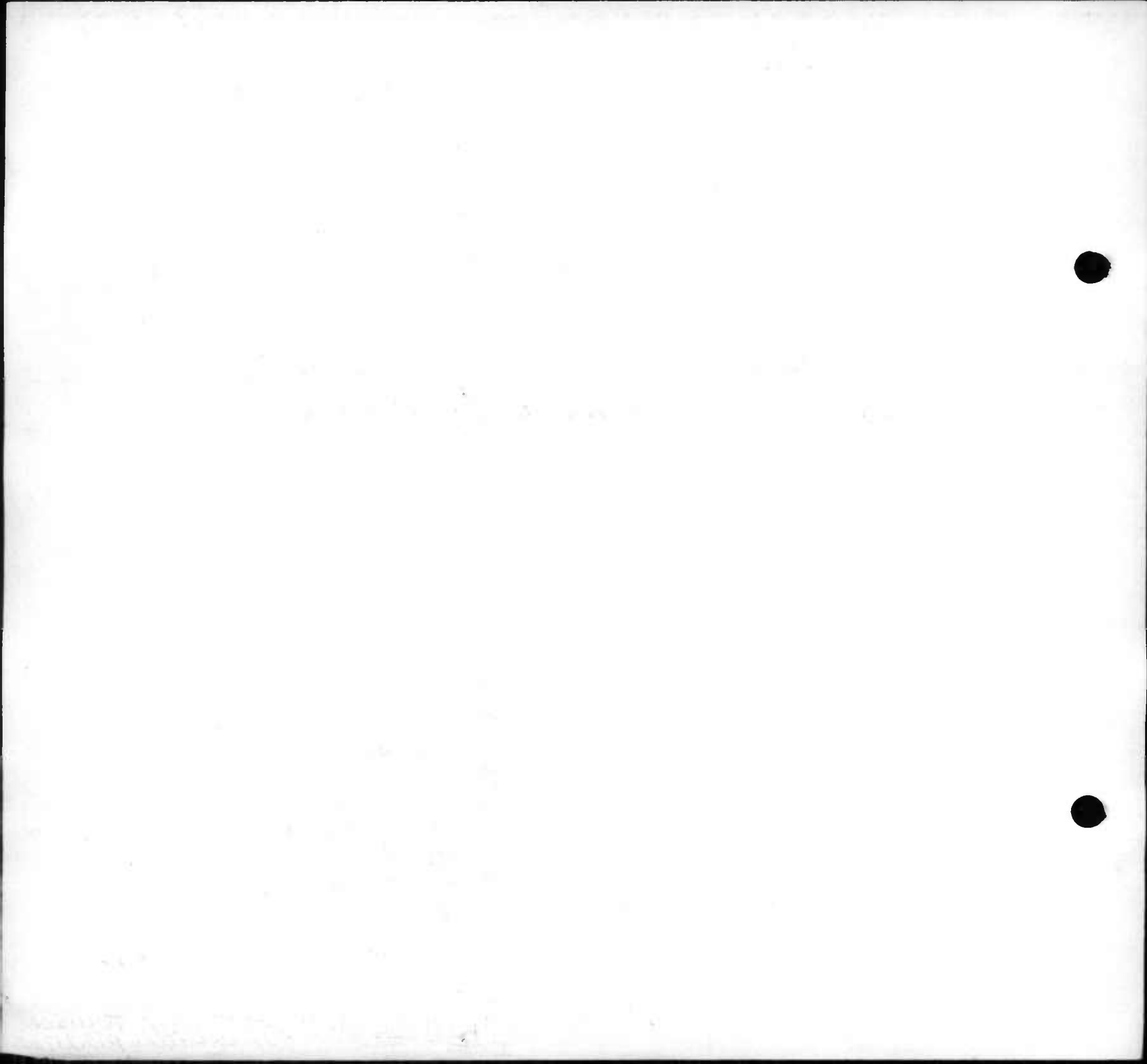
100-105

100-105

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08093	
CERTIFICATE OF DEATH				REG. NO. 72 08093	
STATE OF MARYLAND - DEATH					
BIRTH NO. <u>72-10472</u> <u>08093</u>		2. DATE AND HOUR OF DEATH <u>7/23/72</u> <u>1:25 am</u>			
1. NAME OF DECEASED (Type or Print) <u>DAVIS BABY BOY</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>UNIVERSITY OF MARYLAND HOSPITAL</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>512 N. Gummort St.</u>			
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/72</u>	9. AGE (in years last birthday) <u>2</u>	10. Under 1 Yr. Months: <u>1</u> Days: <u>2</u> Hours: <u>25</u> Min. <u>1</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>CHERYL DAVIS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>UNIV. HOSP.</u> ADDRESS	
18. <u>726.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>RESPIRATORY FAILURE</u> <u>PREMATURITY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> 19 <u>72</u> to <u>7/22</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>7/22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward H. Cullen</u> M.D.		23B. DATE SIGNED <u>7/22/72</u>		23C. PHYSICIAN'S NAME (Type) <u>EDWARD H. CULLEN M.D.</u>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION		24E. CITY, TOWN, OR COUNTY		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 24 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR <u>Raymond J. Curran</u>	
25D. ADDRESS		25E. ADDRESS			

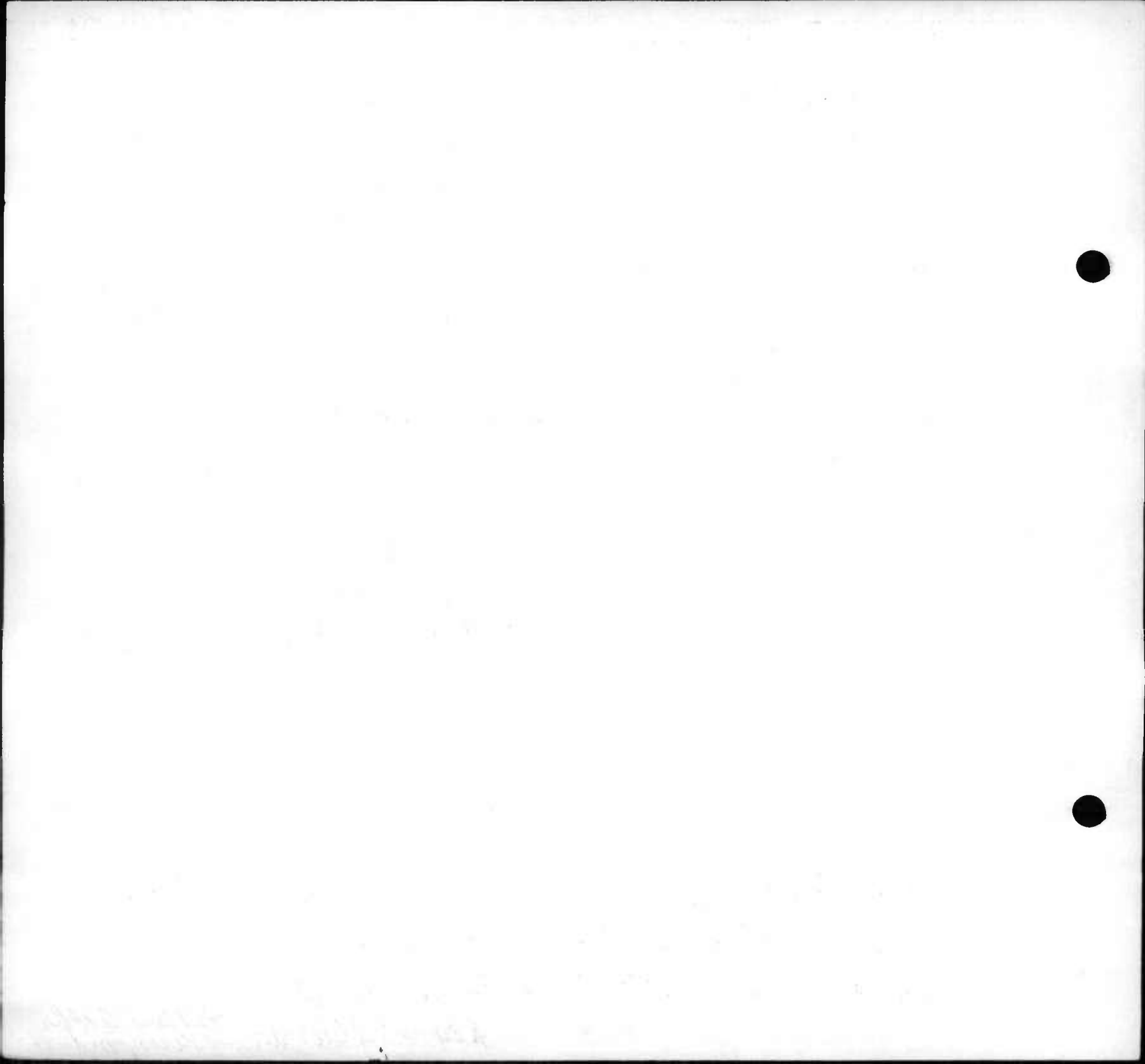




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

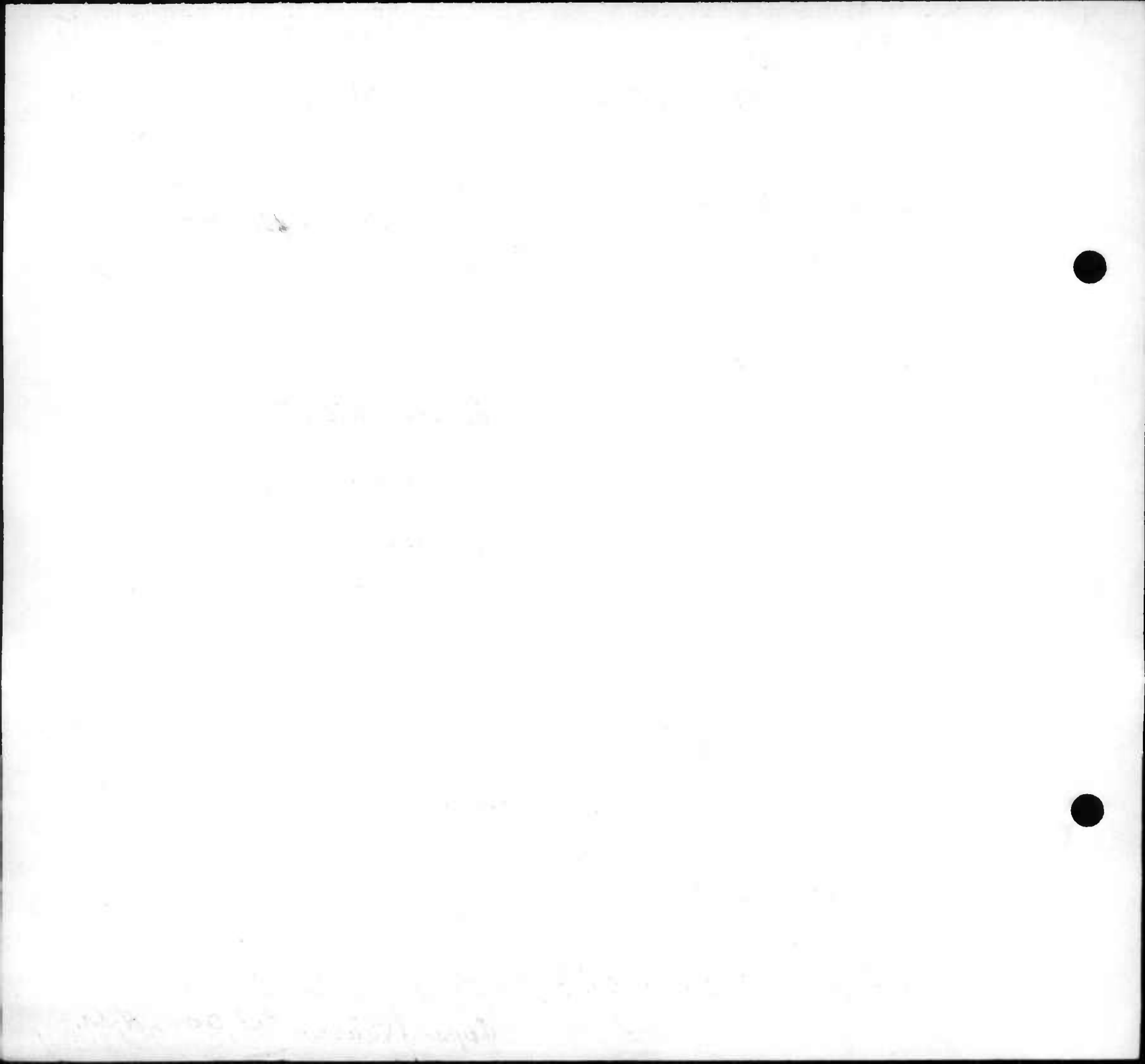
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.
72 08094		72 08094		STATE OF MARYLAND-DHMH
BIRTH NO. <u>W-300</u>		1. NAME OF DECEASED (Type or Print) <u>Wood, Floyd</u>		
2. DATE AND HOUR OF DEATH <u>August 15, 1972</u> <u>7:00</u> A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>University of Maryland Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1403</u>		5. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
6. STREET AND NUMBER <u>548 Robert St</u>		7. SEX <u>M</u> RACE <u>Negro</u>		
8. DATE OF BIRTH <u>9/6/99</u>		9. AGE (In years last birthday) <u>72</u>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clamming, crabbing, etc.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Pollock Wood</u>		
14. MOTHER'S MAIDEN NAME <u>Anna Johnson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>UNIV. HOSP.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-5 hours</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Persistent Pleural Effusion</u>		<u>1 year</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> 19 <u>72</u> to <u>8/15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/15</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Mark H. Kasowitz</u>		23B. DATE SIGNED <u>8/15/72</u>		23C. PHYSICIAN'S NAME (Type) <u>MARK H. KASOWITZ MD</u>
24A. BURIAL CREATION REMOVAL (Specify)		24B. DATE <u>8-22-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Eastern Shore of Md. B. H. Ind</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 24 1972</u>		25B. NAME OF REGISTRAR <u>Ludwig W. Gordon</u>		25C. FUNERAL DIRECTOR <u>Raymond J. Curran</u>
25D. ADDRESS <u>857 Seaboard Ave. Baltimore, Md.</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-236		BALTIMORE CITY HEALTH DEPARTMENT		STATE OF MARYLAND - M-42-38-96		72 08095	
BIRTH NO. 72-12919		72 08095		REG. NO.		72 08095	
1. NAME OF DECEASED (Type or Print) <b>BABY BOY ROYSTER</b>				2. DATE AND HOUR OF DEATH <b>8/17/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>BALTIMORE CITY</b> B. COUNTY <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4300 Adelle Terrace</b>			
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/16/72</b>	9. AGE (In years last birthday) <b>18</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Royster</b>				14. MOTHER'S MAIDEN NAME <b>Theresa</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Univ. Hosp.</b>		ADDRESS	
18. <b>772.01</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>PREMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>PRIMARY APNEA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>INTERNAL, POSSIBLY CNS BLEEDING</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>12 hrs</b> <b>UNKNOWN</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8/16/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/16/72</b> 19 <b>72</b> to <b>8/17</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/17</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S. Allan Bock, M.D.</b>				23B. DATE SIGNED <b>8/17/72</b>		23C. PHYSICIAN'S NAME (Type) <b>S. ALLAN BOCK, M.D.</b>	
23D. ADDRESS <b>Univ of Md. Hospital</b>							
24A. BURIAL CREMATION REMOVAL <b>Cremation</b>		24B. DATE <b>8-22-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Univ of Md. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balt, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Thornton</b>		25C. FUNERAL DIRECTOR <b>Raymond Curran</b>		25D. ADDRESS <b>817 Sangster, Towson, Md 21204</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08096</b>	
W-252 BIRTH NO.		72 08096		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		<b>NICHOLAUS WOZNYJ</b>		2. DATE AND HOUR OF DEATH <b>August 23, 1972</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <b>Maryland</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 117 N. Lakewood Avenue</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY <b>602</b>	
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>117 N. Lakewood Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1901</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ukraine</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Rnat Woznyj</b>		14. MOTHER'S MAIDEN NAME <b>Katherine</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-30-2496</b>		17. INFORMANT <b>Mrs Nadia Woznyj 117 N. Lakewood Ave.</b>	
18. <b>162 / I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Ca</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ca of left lung</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1 yr</b> <b>1 yr</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerotic heart disease</b> <b>Coronary insufficiency</b>				<b>2 yrs</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/4</b> 19 <b>70</b> to <b>8/23</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>7/3</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Samuel Morrison, MD</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8/24/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAMUEL MORRISON</b>		23D. ADDRESS <b>11 E. Chase St Balto Md 21202</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-26-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Michael Ukrainian</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Adrienne Weston</b>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeller Inc.</b>		25D. ADDRESS <b>1901-07 Eastern Ave.</b>			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>W-308 72 08097</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. 72 08097</p> <p><b>STATE OF MARYLAND - DUMFRIES</b></p>	
<p>BIRTH NO. <b>W-308</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>MARIE C. WHITE</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>Aug. 20 '72 10<sup>50</sup> PM</b></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Maryland</b></p> <p>B. COUNTY <b>903</b></p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><b>The Union Memorial Hosp.</b></p>	
<p>6. SEX <b>Female</b></p>	<p>7. RACE <b>White</b></p>	<p>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>9. DATE OF BIRTH <b>April 10, 1906</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><b>Seamstress</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country)</p> <p><b>Baltimore, Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><b>U.S.A.</b></p>	
<p>13. FATHER'S NAME</p> <p><b>William Luckan</b></p>		<p>14. MOTHER'S MAIDEN NAME</p> <p><b>Eva Vey</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <b>216-05-8019</b></p>	
<p>17. INFORMANT</p> <p><b>Mrs. Roselin Bosley</b></p>		<p>ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>Acute pul. edema</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19. ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>Acute myocardial infarction</b></p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p> <p><b>No</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Aug 20 1972</b> to <b>Aug 20 1972</b>, that (I) (we) last saw the deceased alive on <b>Aug 20 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p><b>Chung-Hsien Yu M.D.</b></p>		<p>23B. DATE SIGNED</p> <p><b>Aug 20, '72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p><b>CHUNG-HSIEN YU</b></p>		<p>23D. ADDRESS</p> <p><b>The Union Memorial Hosp. Baltimore, MD, 21218</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><b>Burial</b></p>		<p>24B. DATE</p> <p><b>8-25-1972</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY</p> <p><b>Schwartz</b></p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p><b>Baltimore, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><b>AUG 24 1972</b></p>		<p>25B. NAME OF REGISTRAR</p> <p><b>Lilly &amp; Zeiler Inc.</b></p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>ADDRESS</p> <p><b>1901-07 Eastern Ave.</b></p>	



MARY C. WHITE

April 10, 1906

x

Female White

U.S.A.

Baltimore, Maryland

Genesee

The Very

William Jackson

210-07-5009 Mrs. Rosaline Doolay

Baltimore, Maryland

Scientist

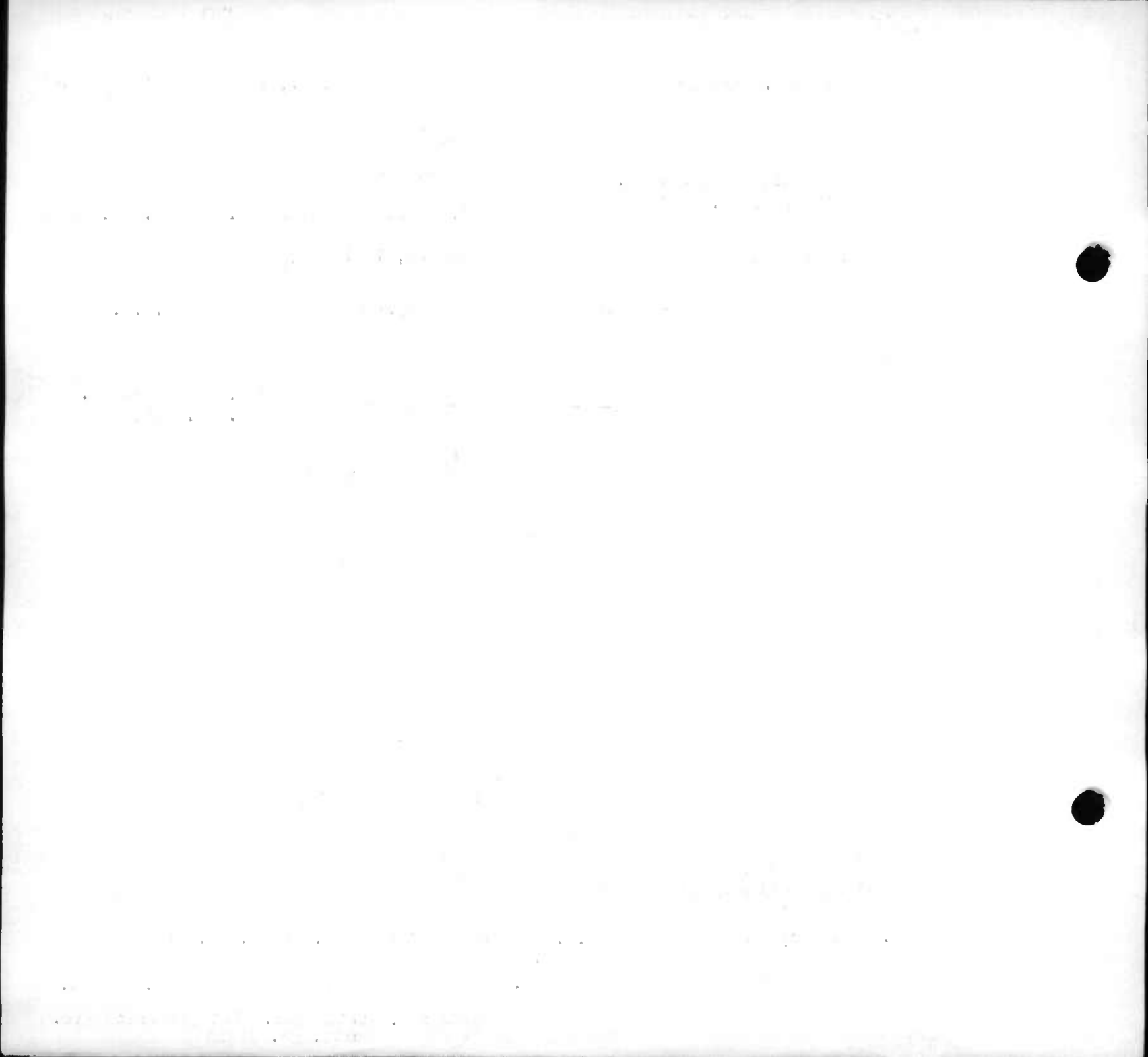
8-22-1975

Bureau

1111 S. Capitol Ave. 1900-07 Jackson Ave.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08098	
W-436		72 08098	
<b>CERTIFICATE OF DEATH</b>			
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Robert E. Walters</b>		2. DATE AND HOUR OF DEATH <b>August 21, 1972</b> <b>6:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 333 South Smallwood St. Baltimore, Md. 21223</b>		A. STATE <b>Maryland</b> B. COUNTY <b>2005</b>	
		C. CITY OR TOWN <b>Baltimore</b>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>333 South Smallwood St. Balto. Md. 21223</b>	
5. SEX <b>male</b>	6. RACE <b>caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1901</b>
		9. AGE (in years last birthday) <b>71</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Electronics</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Walters</b>		14. MOTHER'S MAIDEN NAME <b>Nora Maude</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-03-5956A</b>	
		17. INFORMANT <b>Wife- Clara Walters</b> ADDRESS <b>333 S. Smallwood St. Balto. Md. 21223</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Carcinoma of the lungs</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Myocardial Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 10</b> 19 <b>60</b> to <b>Aug 22</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Aug 22</b> 19 <b>72</b> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Henry Armanas</b>		23B. DATE SIGNED <b>Aug 23, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Henry Armanas</b>		23D. ADDRESS <b>M.D. 1934 Wilkins Ave. Balto. Md. 21223</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/24/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>DORSEY HOWARD CO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. ...</b>	
25C. FUNERAL DIRECTOR <b>George L. Schwab Inc.</b>		ADDRESS <b>2101 Frederick Ave. Balto. Md. 21223</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-623</b>      <b>72 08099</b>      <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 08099</b> <b>STATE OF MARYLAND-DHMH</b></p>	
<p>BIRTH NO. <b>1</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>FRANCIS C. BRAXTON</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>AUG. 21 1972 11:27 PM.</b></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>9-13-72</b></p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2552</b></p>		<p>5. SEX <b>M.</b> 6. RACE <b>W.</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH <b>1910</b> 9. AGE (In years last birthday) <b>62</b></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE MAN</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Virginia</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>OSCAR</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Mary</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>214-05-3183</b></p>	
<p>17. INFORMANT <b>Eva Braxton</b> ADDRESS <b>433 Swale Rd</b></p>		<p>18. <b>4-10-91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Pulmonary edema</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>	
<p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b> PROBABLE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: <b>abnormal Q wave</b> (B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE SEVERAL YRS. DUE TO, OR AS A CONSEQUENCE OF: (C) Rheumatic aortic stenosis</p>	
<p>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>RHEUMATIC HEART DISEASE</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>50+ YRS.</b></p>	
<p>21A. DATE OF OPERATION <b>2</b> 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <b>YES</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>8/19 1972</b> to <b>8/21 1972</b> that (I) (we) last saw the deceased alive on <b>8/21 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Robert J. Bauer, M.D.</b></p>		<p>23B. DATE SIGNED <b>8/21/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>ROBERT J. BAUER, M.D.</b></p>		<p>23D. ADDRESS <b>3001 S. HANOVER ST. BALTIMORE, MD</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>8-26-72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Brooklyn, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Andrew Johnson</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Charles E. Rue</b></p>		<p>ADDRESS <b>1300 Eutaw Pl.</b></p>	

9-13-1972 - Correction form from Funeral Director - Charles A. Rice, 1300 Eutaw Place,  
Balto., Md. HRS

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>72 08100</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 08100</u>	
STATE OF <u>MARYLAND</u> -DHMH		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HENRY S. STEFANOWICZ</u>		2. DATE AND HOUR OF DEATH <u>8-19-72 3:20 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>104</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home + Hosp.</u> <u>BALTO. MD. 21231</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2637 FAIT AVE 21224</u>					
5. SEX <u>M</u>	6. RACE <u>A</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-19</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>					
13. FATHER'S NAME <u>JOHN STEFANOWICZ</u>		14. MOTHER'S MAIDEN NAME <u>ANIELA PIEKARSKA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWII NAVY</u>		16. SOCIAL SECURITY NO. <u>217-03-7421</u>		17. INFORMANT <u>MRS. AGNES STEFANOWICZ</u>	
18. <u>4-10-71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>recent</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>INJURY OCCURRED</u>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> and that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. GONGON M.D.</u>		23B. DATE SIGNED <u>8-19-72</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. GONGON</u>	
23D. ADDRESS <u>100 N. BRADWAY, BALTO. MD. 21231</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/23/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Co. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 24 1972</u>		25B. NAME OF REGISTRAR <u>Anthony J. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Raymond L. Kaczorowski</u>	
25D. ADDRESS <u>2525 FLEET ST.</u>					

200

72

20

James H. Thompson



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08101

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Cedric Watts</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 22 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month 8 Day 22 Year 72 Hour 2:00 p. M.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Nov. 4, 1914</b>		10. AGE (In years last birthday) <b>57</b>	
11. BIRTHPLACE (State or foreign country) <b>Hickory N.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Watts</b>		14. MOTHER'S MAIDEN NAME <b>Pearl</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W. 2.</b>		18. SOCIAL SECURITY NO. <b>214-18-2385</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Subdural hematoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fatty metamorphosis of liver</b>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>unk. unk. m.</b>		22F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1915 Oakhill Avenue</b>	
22G. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22H. HOW DID INJURY OCCUR? <b>Subject allegedly fell.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>8/23/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/24/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Calvary Cem.</b>		24D. LOCATION (City, town or county) (State) <b>Cedar Hill, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Brown</b>	
25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		25D. ADDRESS <b>319 N. Holladay St.</b>	

11-12-57

BY

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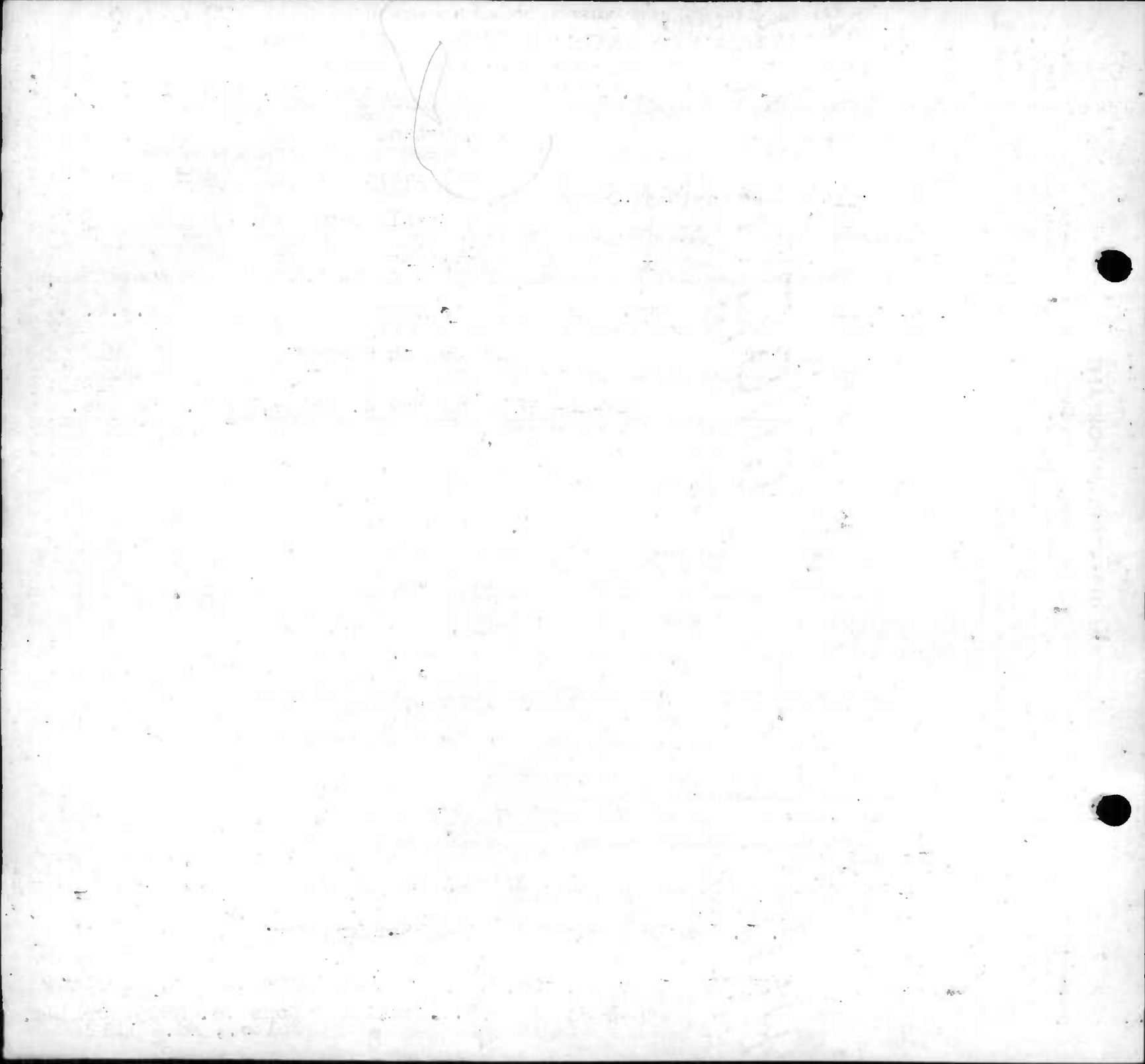
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11-12-57

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 08102 STATE OF MARYLAND - DIME
BIRTH NO. <b>K-260</b>		72 08102		
1. NAME OF DECEASED (Type or Print) <b>MARIE (MARY) F. KUSSER</b>		2. DATE AND HOUR OF DEATH <b>August 22, 1972 12:50 P.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Hamilton Nursing Center</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2710</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4704 Alhambra Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/23/1887</b>	9. AGE (In years last birthday) <b>85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Richard Fischer</b>		14. MOTHER'S MAIDEN NAME <b>Joseph Herbert</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-48-9725</b>		17. INFORMANT ADDRESS <b>21210 Richard J. Meise, 105 W. Lake Ave.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma colon</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Peptic ulcer</b>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>19 67</b> to <b>Aug 22</b> 19 <b>72</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>August 7</b> 19 <b>72</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did not)</del> view the body after death.				
23A. SIGNATURE <b>R. Donald Jandorf</b>		23B. DATE SIGNED <b>8-23-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. R. Donald Jandorf</b>		23D. ADDRESS <b>7403 Harford Road</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/24/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 24 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-256		72 08103		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08103	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ashmore, Miss Ruby B.</i>		2. DATE AND HOUR OF DEATH <i>8-23-72</i>		STATE OF MARYLAND - <i>DEATH</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i>		B. COUNTY <i>BALTO 5300</i>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-29-1919</i>	
9. AGE (In years last birthday) <i>52</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Harold B. Ashmore</i>				14. MOTHER'S MAIDEN NAME <i>Clara Barry</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-14-7035</i>		17. INFORMANT <i>Miss Corinne I. Ashmore</i>		ADDRESS <i>Same</i>	
18. <i>183.0</i>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sepsis renal failure</i>				<i>4 day</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Bowel gangrene</i>				<i>3 day</i>	
		(C) <i>Radiation gastroenteritis</i>				<i>8 months</i>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>8/23</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/18/72</i> to <i>8/23/72</i> and that (I) (we) last saw the deceased alive on <i>8/23/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>S. Songcharoen</i>				23B. DATE SIGNED <i>8/23/72</i>		23C. PHYSICIAN'S NAME (Type) <i>S. SONGCHAROEN, M.D.</i>	
23D. ADDRESS <i>Mercy Hospital</i>		23E. DEGREE		23F. DEGREE		23G. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-25-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn</i>		24D. LOCATION (City, town, or county) (State) <i>Woodlawn Balto. Co., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 24 1972</i>		25B. NAME OF REGISTRAR <i>Adrian Johnson</i>		25C. FUNERAL DIRECTOR <i>H. W. Jenkins &amp; Sons Co.</i>		ADDRESS <i>4905 York Road Balto., Md. 21212</i>	

10/30/72 - Radiation given  
for clear cell carcinoma  
of ovary causing necrosis  
+ radiation gastroenteritis  
Letter from Mercy Hospital - Filed  
in Bur. of Prostatisties - 9c



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

72 08104

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EDWARDS, WILLIAM CURTIS

2. DATE AND HOUR OF DEATH

AUGUST 21, 1972 9:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

38 N ATHOL AVE BALTO MD 21229

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

04 22 07

9. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SECURITY GUARD

10B. KIND OF BUSINESS OR INDUSTRY

DETECTIVE AGENCY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM MURRAY EDWARDS

14. MOTHER'S MAIDEN NAME

ELLEN ( DURHAM )

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW 2

16. SOCIAL  
SECURITY NO.

228 05 2029

17. INFORMANT

ST AGNES HOSPITAL RECORDS CATON &  
WILKENS AVES BALTO MD 21229

ADDRESS

18. 162.1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE TERMINAL CARCINOMA - LUNG  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Chronic obstructive Pul. Disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If In Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from 08 16 19 72 to 08 21 19 72,  
that (X) (we) last saw the deceased alive on 08 21 19 72 and that in (X) (our) opinion death occurred on the date  
and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.

23A. SIGNATURE

Donato A. Vargas Jr

M.D.  
DEGREEAttending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

8-21-72

23C. PHYSICIAN'S  
NAME (Type)

DONATO A VARGAS, JR., M.D., ST AGNES HOSPITAL

23D. ADDRESS

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-24-1972

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION

(City, town, or county)

Pikesville, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 25 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>A-322</b>		72 08105		CITY HEALTH DEPARTMENT		72 08105	
1. NAME OF DECEASED (Type or Print) <b>ATKISSON, HORACE M.</b>				2. DATE AND HOUR OF DEATH <b>AUGUST 22, 1972 12:18 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE 21227</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>ROUTE # 1 7421 WASHINGTON BLVD</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>05/17/21</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REPAIRMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GLASS &amp; RADIATOR</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>C. ANDREW ATKISSON</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE MUSSELMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W W 2</b>		16. SOCIAL SECURITY NO. <b>227-18-9272</b>		17. INFORMANT <b>BALTO MD 21229</b>		ADDRESS <b>ST AGNES' RECORDS CATON &amp; WILKENS AVE S</b>	
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Severe Anemia 2. to Liver Cirrhosis</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Heart Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>AUGUST 12 19 72</b> to <b>AUGUST 22 19 72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>AUGUST 22 19 72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. A. Varga Jr.</b>						23B. DATE SIGNED <b>8-22-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>M.D. DEGREE</b>				23D. ADDRESS <b>DEGREE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Washington Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Sandston, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard-4107 Wilkens Ave-21229</b>			

RECEIVED

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

ST. LOUIS, MO. AUGUST 10, 1934

MALE CAUCASIAN

RECEIVED

ALL INFORMATION

ST. LOUIS, MO. AUGUST 10, 1934

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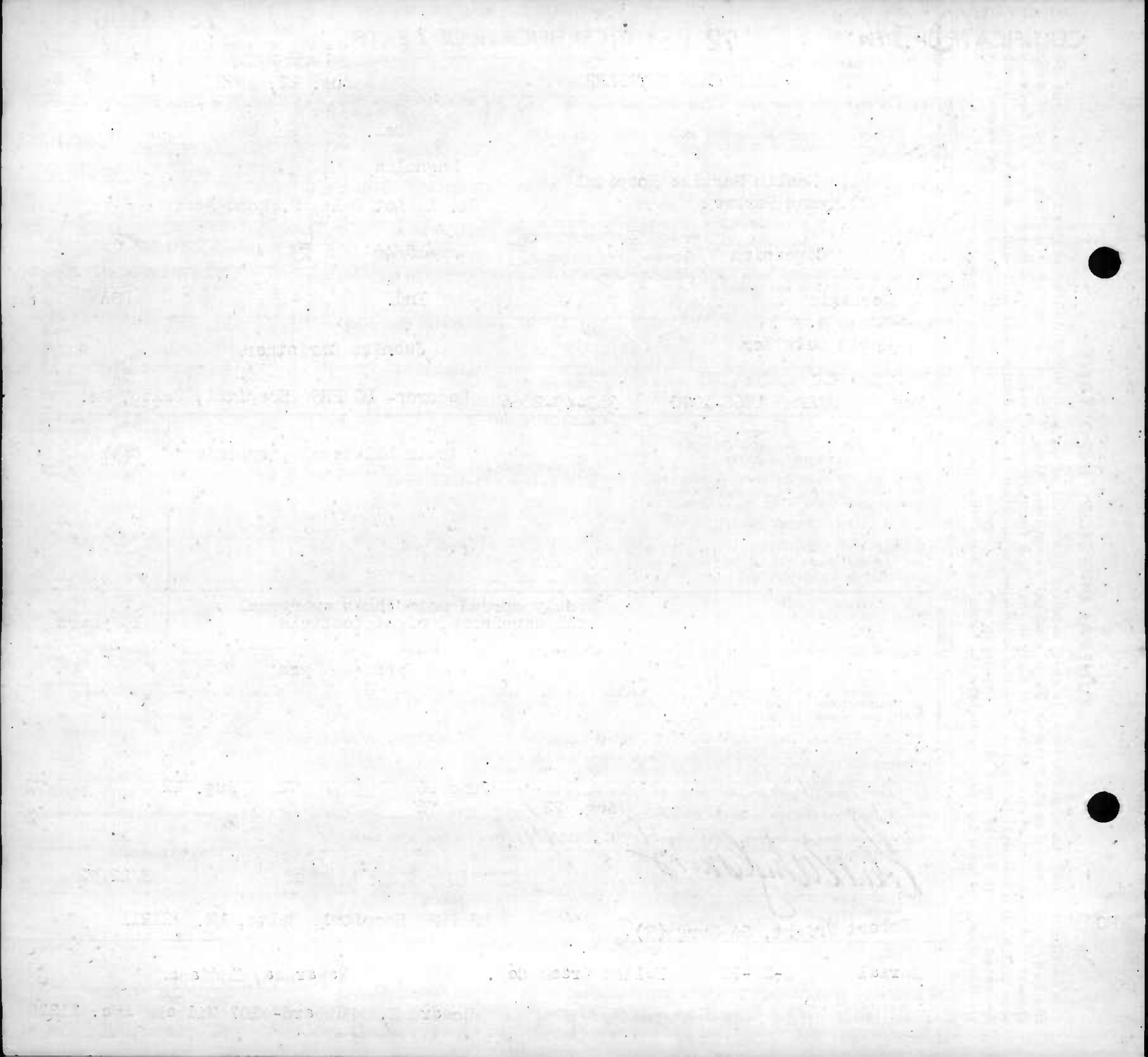
ST. LOUIS, MO. AUGUST 10, 1934

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. 72 08106
72 08106 CERTIFICATE OF DEATH						STATE OF MARYLAND
1. NAME OF DECEASED (Type or Print) DONALD DEAN DETWILER			2. DATE AND HOUR OF DEATH Aug. 22, 1972 6 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Del. B. COUNTY V07 C. CITY OR TOWN Magnolia D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Rt. 1 Lot B 1 S. Wood Acres			
5. SEX M	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/46	9. AGE (In years last birthday) 25	10. Under 1 Yr. Months: Days Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME M. Noble Detwiler			14. MOTHER'S MAIDEN NAME Juanita Christner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USAF 1966-1970			16. SOCIAL SECURITY NO. 313-48-2066		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 486X I + 186X Acute bilateral pneumonia			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute bilateral pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Widely spread metastases embryonal cell carcinoma, right testicle					1 1/2 years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 16 19 72 to Aug. 22 19 72, that (I) (we) last saw the deceased alive on Aug. 22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <i>Robert Wright</i>			23B. DATE SIGNED 8/22/72			
23C. PHYSICIAN'S NAME (Type) Robert Wright, SA Surg (R)			23D. ADDRESS US PHS Hospital, Balto, Md. 21211			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-26-72	24C. NAME OF CEMETERY OR CREMATORY Yellow Creek Cem.	24D. LOCATION (City, town, or county) (State) Wakarusa, Indiana			
25A. DATE REC'D BY HEALTH DEPT. AUG 25 1972		25B. NAME OF REGISTRAR <i>Sidney S. Hubbert</i>	25C. FUNERAL DIRECTOR Howard H. Hubbard-4107 Wilkens Ave. 21229		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300				72 08107		CERTIFICATE OF DEATH		REG. NO. 72 08107		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>Charles Beattie</b>				2. DATE AND HOUR OF DEATH <b>8/22/72 10.45 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>V35</b> C. CITY OR TOWN <b>Berlin</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Rt. 4, Box 167 15530</b>							
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-14-56</b>	9. AGE (in years last birthday) <b>16</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Beattie, Sr.</b>				14. MOTHER'S MAIDEN NAME <del>Decker</del> <b>Frances Yoder</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: BCH-4940 Eastern Ave., Baltimore, Md.</b> ADDRESS <b>21224</b>					
18. <b>204.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Lymphocytic Leukemia 11 months</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Hemorrhage</b> (B) <b>Acute Lymphocytic Leukemia</b> (C) <b>11 months</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/5</b> 19 <b>72</b> to <b>8/22</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/21</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Michele Codini M.D.</b>				23B. DATE SIGNED <b>8/22/72</b>				23C. PHYSICIAN'S NAME (Type) <b>Michele Codini</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8-25-72</b>				24C. NAME of CEMETERY or CREMATORY <b>I.O.O.F. Cemetery</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>				25B. NAME OF REGISTRAR <b>Tridney</b>				25C. FUNERAL DIRECTOR <b>Hubbard Funeral Home 4107 Wilkens Ave. 21229</b>			
25D. LOCATION <b>Berlin, Pennsylvania</b>				25E. ADDRESS <b>Hubbard Funeral Home 4107 Wilkens Ave. 21229</b>							



Chlorine Dioxide

Acute hypoxia  
respiratory distress

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8/5/8 25 25 25

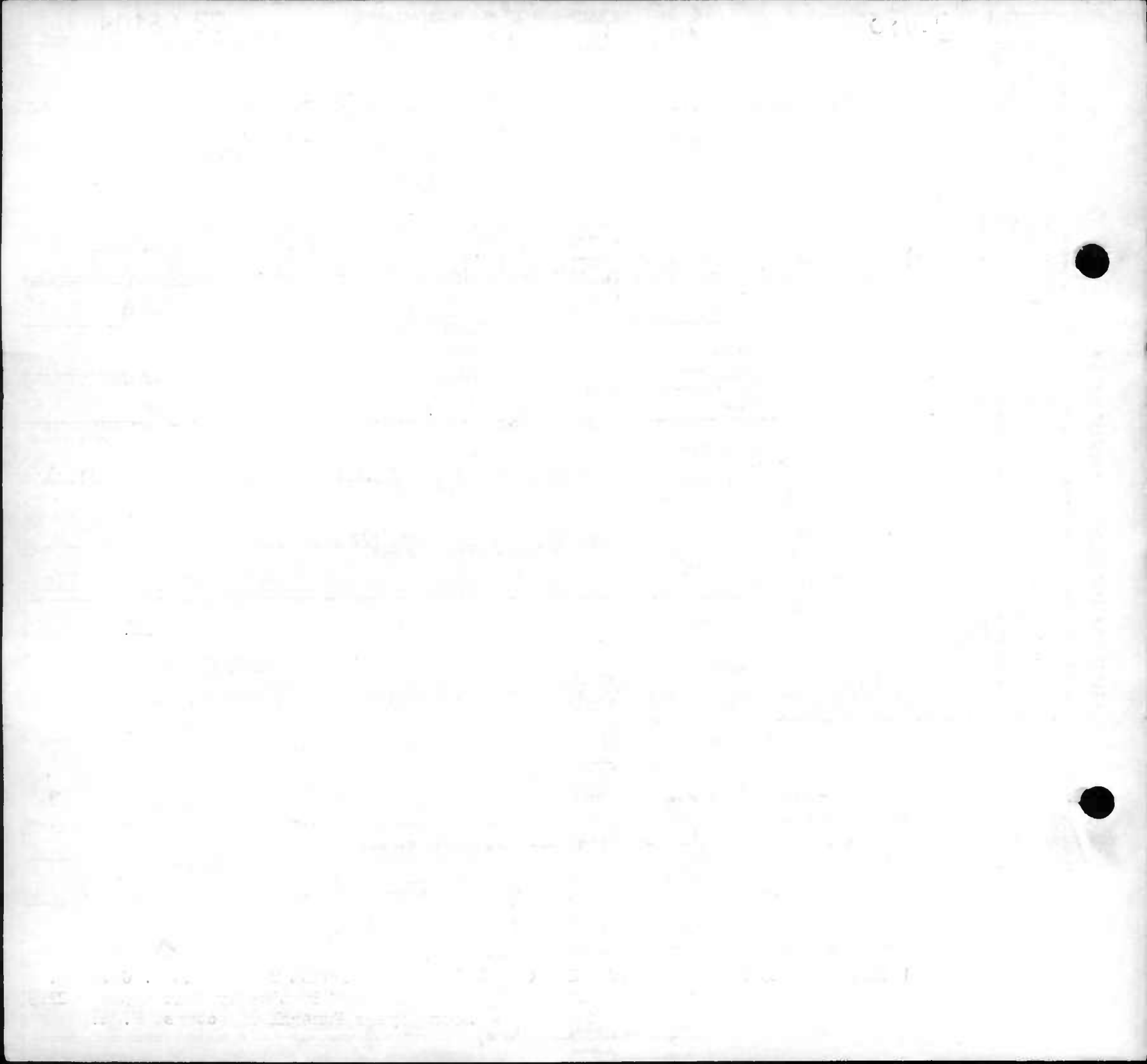
8/5/8 25 25 25



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08108		72 08108	
C-400		72 08108		72 08108	
1. NAME OF DECEASED (Type or Print) <u>Charles H. Clay</u>		2. DATE AND HOUR OF DEATH <u>8/22/72</u> <u>11</u> <u>20</u> <u>a.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Clay's Lane</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/49</u>	9. AGE (in years last birthday) <u>73</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Army</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HENRY CLAY</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA MIHM</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>220-14-1530</u>		17. INFORMANT <u>Miss Barbara Clay</u> ADDRESS <u>Same</u>	
18. <u>444.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Aspiration of gastric vomitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Gastric dilatation (post-operative)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>75 min</u> <u>75 min</u> <u>7 days (op)</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Active gastro-intest. (upper) bleeding</u>		<u>75 min</u>	
19A. DATE OF OPERATION <u>8/15/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Mesent. thrombosis</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>8/14</u> 19 <u>72</u> to <u>8/22</u> 19 <u>72</u> that (we) last saw the deceased alive on <u>8/22</u> 19 <u>72</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jerry Herbst MD</u>		23B. DATE SIGNED <u>8/22/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Jerry Herbst M.D.</u>	
23D. ADDRESS <u>Maryland General Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>8/25/1972</u>		24C. NAME of CEMETERY or CREMATORY <u>MOUNT OLIVE CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN BALTO. CO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 25 1972</u>		25B. NAME OF REGISTRAR <u>Loring Byers</u>		25C. FUNERAL DIRECTOR <u>8728 Liberty Road</u> ADDRESS <u>211-33</u>	
VS 150-REV. 1/1/68		Loring Byers Funeral Directors, P. A.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>B-542</i>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>72 08109</i>	
1. NAME OF DECEASED (Type or Print) <i>Shawn Bonolis</i> <i>BONOLIS IS BABY GIRL</i>		2. DATE AND HOUR OF DEATH <i>August 22, 1972</i> <i>10:19 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>BALTIMORE CITY HOSPITALS</i> 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN <i>Dundalk</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i> 6. RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-20-72</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dependent</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>2</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Vincent P. Bonolis</i>	
14. MOTHER'S MAIDEN NAME <i>Dorothy E. Betz</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>BCH: RECORDS Baltimore, Maryland 21224</i>		18. CAUSE OF DEATH <i>77821</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Prematurity</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Severe metabolic acidosis</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Multiple Erythema &amp; Bruise leading to asphyxia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1430 PM 8-21-72</i> 19 <i>72</i> to <i>8-22-1972</i> that (I) (we) last saw the deceased alive on <i>8-22-72</i> 19 <i>72</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Heaw</i>		23B. DATE SIGNED <i>8-22-72</i>		23C. PHYSICIAN'S NAME (Type) <i>AIJAZ AKRAIN</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-24-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		24E. NAME OF REGISTRAR <i>Sidney</i>		24F. FUNERAL DIRECTOR <i>John J. Duda</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 25 1972</i>		25B. NAME OF REGISTRAR <i>Sidney</i>		25C. FUNERAL DIRECTOR <i>John J. Duda</i>	
25D. ADDRESS <i>7922 Wise Ave. Dundalk, Md. 21222</i>					

14-00000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08110	
W-452		72 08110	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		STATE OF MARYLAND - DEATH	
Golden L. Williams		645 P. M.	
2. DATE AND HOUR OF DEATH		8/23/72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Church Home & Hospital		Md. Baltimore	
5 Church Home and Hospital		C. CITY OR TOWN Dundalk	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 3431 Yardley Dr.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	02-27-11
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Painter Carpenter		Tennessee	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
William P. Williams		U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME	
No		Jane Watts	
16. SOCIAL SECURITY NO.		17. INFORMANT (Wife) 3431 Yardley Drive	
4-10 05 5358		Mrs. Roberta E. Williams, Dundalk, Md.	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		2 days	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		Liver Damage Based on Obs. Peritonitis	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		Second A of the Liver with unknown origin	
		(C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
8/21/72		Bowel opst. Peritonitis	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/21 1972 to 8/23 1972 that (I) (we) last saw the deceased alive on 8/23 1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Mohammed Teliach		8/23/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Mohammed Teliach		28-T Richman Rd Owings Mills Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		8/26/72	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Higgins Chapel Cemetery		Erwin, Tennessee	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
AUG 25 1972		John J. Duda	
25C. FUNERAL DIRECTOR		ADDRESS	
John J. Duda		7922 Wise Ave. Dundalk, Md.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08111		REG. NO. 72 08111	
M-250				72 08111		STATE OF MARYLAND-DEM	
BIRTH NO.				CERTIFICATE OF DEATH		72 08111	
1. NAME OF DECEASED (Type or Print) <b>Edward G. McKinney</b> <b>EDWARD G. MCKINNEY</b>				2. DATE AND HOUR OF DEATH <b>8. 21. 72</b>   <b>11. 25 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>5 Bayside Drive</b> <b>5 BAYSIDE DRIVE, 21222</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/5/1907</b>		9. AGE (In years last birthday) <b>65</b>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Driver</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Humble Oil Co. company</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>ERNEST MCKINNEY</b>				14. MOTHER'S MAIDEN NAME <b>LETTIE GREEN.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-01-5962</b>		17. INFORMANT Wife: <b>Mrs. Mable E. McKinney</b> ADDRESS: <b>5 Bayside Drive Dundalk, Md. 21222</b>	
18. <b>412131</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>COPD, ASCVD, CHF</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>Long Standing</b>	
(C) <b>E Old MI.</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8. 14. 1972</b> to <b>8. 21. 1972</b> that (I) (we) last saw the deceased alive on <b>8. 21. 1972</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Satpal Singh M.D.</b>				23B. DATE SIGNED <b>8. 21. 72.</b>		23C. PHYSICIAN'S NAME (Type) <b>SATPAL SINGH M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b>				24E. ADDRESS <b>Church Home &amp; Hospital.</b>			
25A. DATE RECD. BY HEALTH DEPT. <b>AUG 25 1972</b>				25B. NAME OF REGISTRAR <b>Andrew Johnson</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b> ADDRESS: <b>7922 Wise Ave. Dundalk, Md. 21222</b>	



3/2/1907

A. 2. 12

W. 1. 12

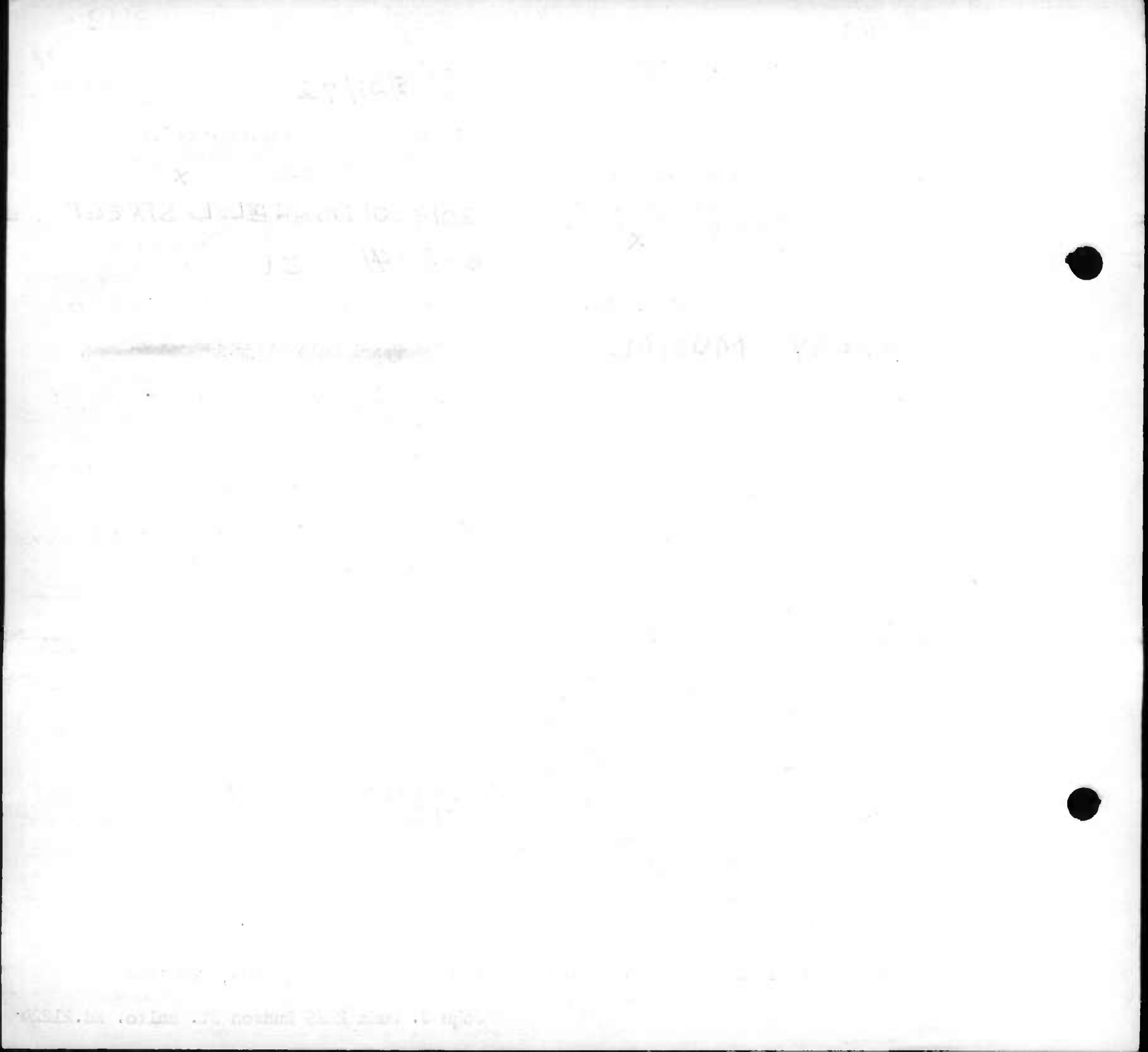
W. 1. 12

W. 1. 12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

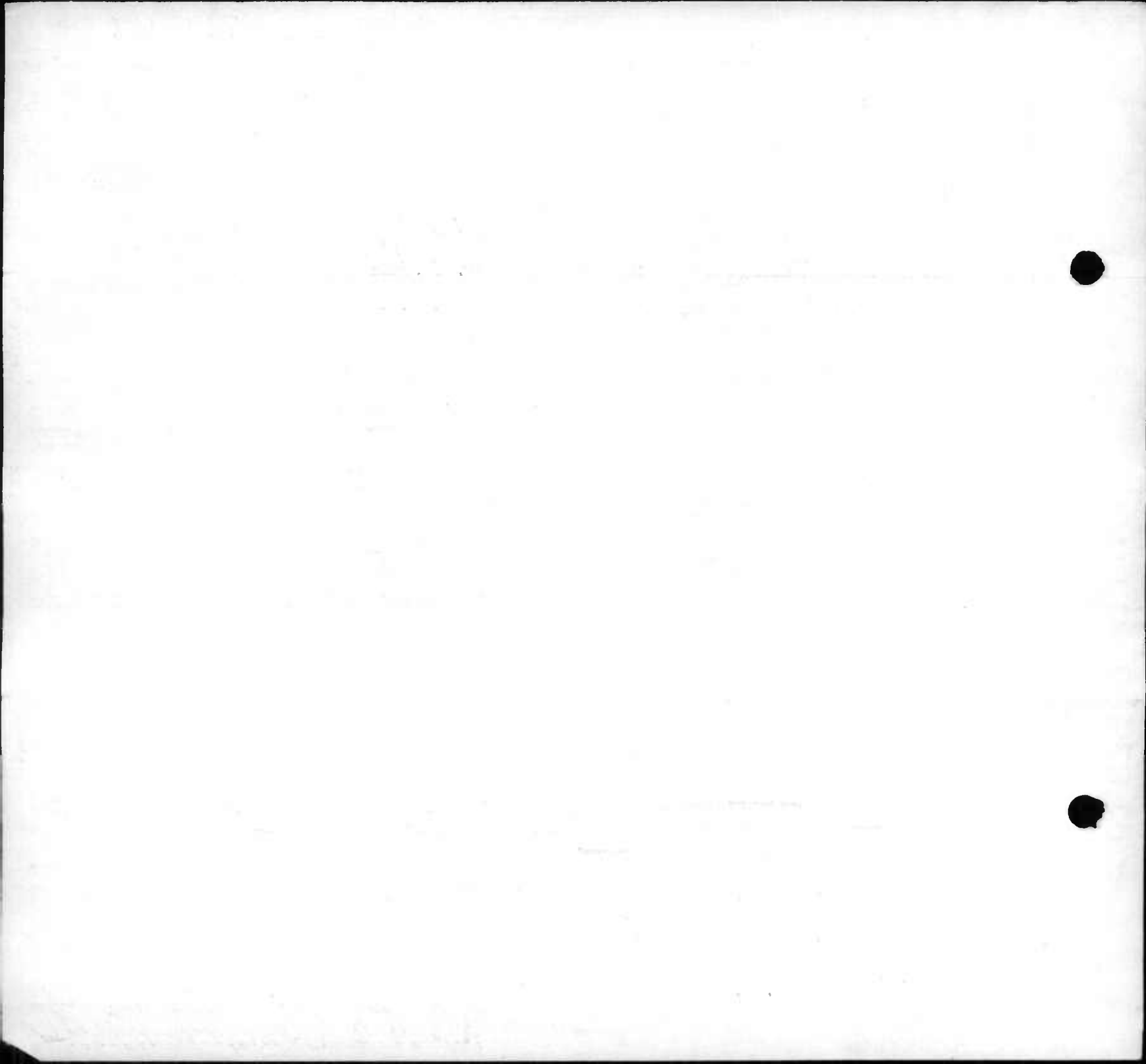
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08112	
M-240 72 08112				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Robert J. Musial		2. DATE AND HOUR OF DEATH 8/21/72 15-15P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Maryland Baltimore city 101		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME and HOSPITAL BALTIMORE Maryland 21231		6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7. STREET AND NUMBER 3019 O'DONNELL STREET	
8. SEX M	9. RACE W	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH 6-6-41	12. AGE (in years last birthday) 31 Yrs	13. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRE MAN		15. KIND OF BUSINESS OR INDUSTRY Balto. City		16. BIRTHPLACE (State or foreign country) MARYLAND	
17. CITIZEN OF WHAT COUNTRY? U.S.A		18. FATHER'S NAME HARRY MUSIAL		19. MOTHER'S MAIDEN NAME Pearl Kolodziejewski	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		21. SOCIAL SECURITY NO. 216 361364		22. INFORMANT DR. G. GURUSWAMY CHURCH HOME and HOSPITAL	
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 571.9 I CAUSE OF DEATH CARDIO RESPIRATORY ARREST		24. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CIRRHOSIS and its compli- (COESOPHAGEAL VARICES) catarrh.		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. not known	
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No) - NO -	
30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
33. TIME OF INJURY (APPROX.)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
36. HOW DID INJURY OCCUR?		37. I certify that (I) (this hospital) attended the deceased from 8/13/72 to 8/21/72		38. that (I) (we) last saw the deceased alive on 8/21/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.	
39. SIGNATURE R. Guruswamy		40. DATE SIGNED 8/21/72		41. ATTENDING PHYSICIAN Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
42. PHYSICIAN'S NAME (Type) RAYMOND ATKINS		43. ADDRESS CHURCH HOME and HOSPITAL		44. DATE REC'D BY HEALTH DEPT. AUG 25 1972	
45. NAME OF REGISTRAR Audrey Johnson		46. FUNERAL DIRECTOR John J. Duda		47. ADDRESS 2829 Hudson St. Balto. Md. 21224	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08113		REG. NO. 72 08113	
BIRTH NO. 6-520		72 08113		STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print) <u>Ida Gaines</u>			2. DATE AND HOUR OF DEATH <u>August 19, 1972</u> <u>4 35</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Harbor View Nursing Home</u> <u>1213 Light St</u>			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Towson</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>8155 Pleasant Plains Road</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u> <u>Nov. 15, 1972</u>	9. AGE (In years lost birthday) <u>85</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u>	
18. <u>433,91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Thrombotic C.V.A.</u> 1 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCD</u> <u>Senility due C.A.S.</u>			CAUSE OF DEATH <u>Cerebral art. scl.</u> <u>ASCD</u> <u>Senility due C.A.S.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Cystocele</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>the hospital</u> attended the deceased from <u>June 1972</u> to <u>8/19</u> 19 <u>72</u> that (1) <u>we</u> last saw the deceased alive on <u>8/19</u> 19 <u>72</u> and that in (my) <u>my</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Kenneth Krulowitz MD</u>				23B. DATE SIGNED <u>8/21/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kenneth Krulowitz MD</u>				23D. ADDRESS <u>115 W. Monument St. Balto Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug. 22, 1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>	
				24D. LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 25 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Whorton</u>		25C. FUNERAL DIRECTOR <u>John Brown Sons, Towson, Md.</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08114

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARY SUE HOLIAR POWERS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 21, 1972</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 21, 1972 2:25 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>August 6, 1930</b>		10. AGE (In years last birthday) <b>42</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		15. MOTHER'S MAIDEN NAME <b>Exie (Smith)</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Exie Hollar - 123 E. Montgomery St. 21230</b>		ADDRESS	
19. <b>180X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Cervix with metastases</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>no (inquiry)</b>	
23. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>8/22/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-23-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whorton</b>	
25C. FUNERAL DIRECTOR <b>Mc Cully - 130 E. Font Ave. Balto. 21230</b>		ADDRESS	

22  
1972  
August 21, 1972  
130 at the time  
North Carolina  
South Carolina  
This matter is in Montgomery  
Commission of Georgia

John H. ...  
John H. ...

John H. ...  
John H. ...



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

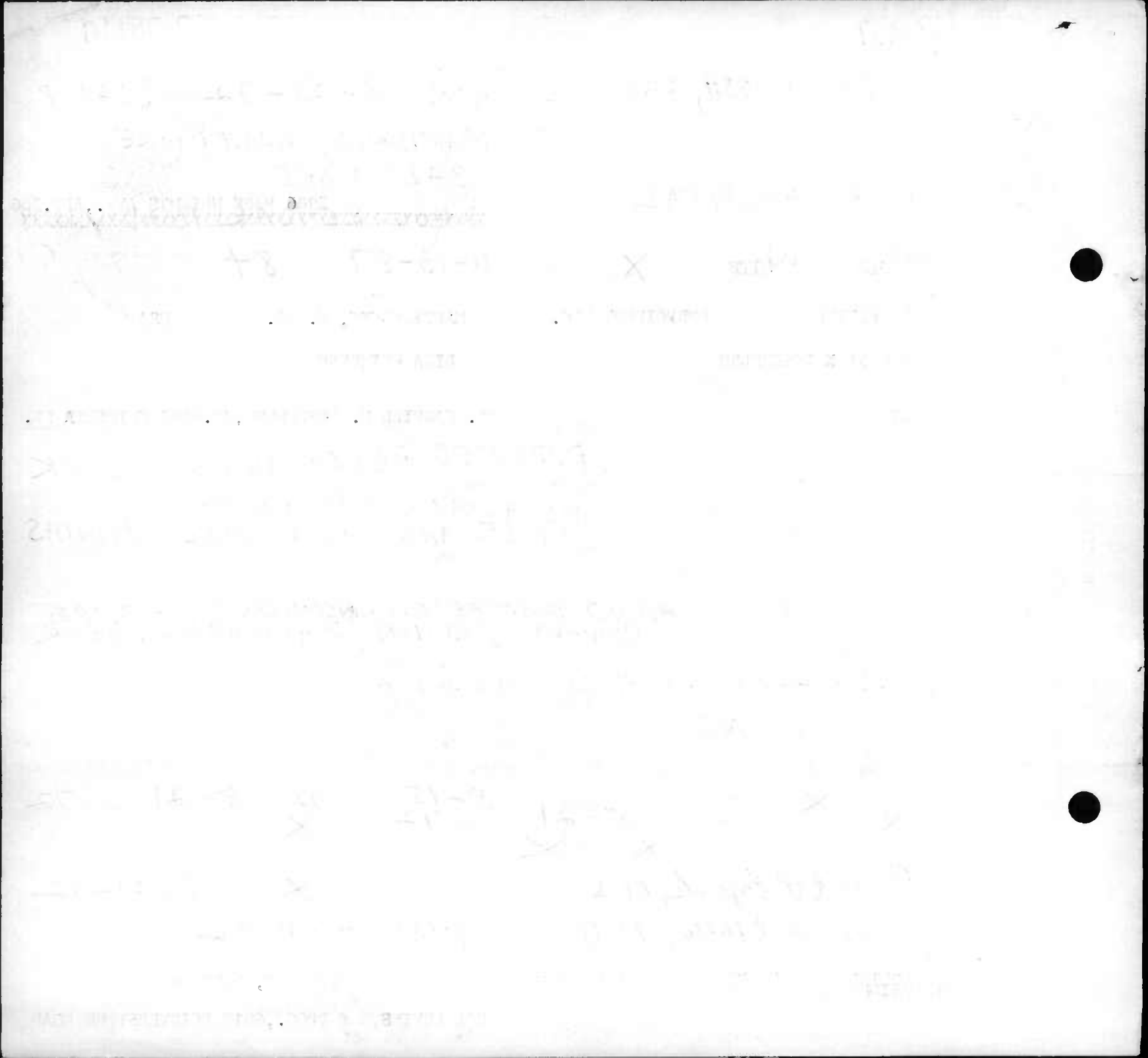
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08115	
72 08115				CERTIFICATE OF DEATH	
BIRTH NO. M-254		1. NAME OF DECEASED (Type or Print) BESSIE E. McNally.		2. DATE AND HOUR OF DEATH 8/23/72 4:25 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSP. 3001, S. HANOVER ST. BALTO MD 21230.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <del>513 E. CLEMENT ST. MD. 21202</del> C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <del>3001, S. HANOVER ST.</del> 513 E. CLEMENT ST.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-1888	9. AGE (In years last birthday) 84.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) BALTO.
13. FATHER'S NAME CHARLES ZIMMERMAN			14. MOTHER'S MAIDEN NAME ALICE ZEPP		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212056144A	17. INFORMANT ADDRESS JAMES R. McNally. 513 E. CLEMENT ST. BALTO MD		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION 8-23-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-14-72 19 to 8-23-72 19 that (I) (we) last saw the deceased alive on 8-23-72 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R.A. DATEL		23B. DATE SIGNED 8/23/72.		23C. PHYSICIAN'S NAME (Type) R.A. DATEL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-26-72		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cent.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 25 1972		25B. NAME OF REGISTRAR Dr. J. H. H. H.	
25C. FUNERAL DIRECTOR ADDRESS McCallie Funeral Home 130 E. Fort Ave. 21230					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08116	
CERTIFICATE OF DEATH				REG. NO. 72 08116	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DEW	
ROSENBUSH, GABRIEL W., SR		8-21-72 6:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL			A. STATE MARYLAND, BALTIMORE 720		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 5906 PARK HEIGHTS AVE. APT. 206		
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-13-87		9. AGE (In years last birthday) 84		10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10B. KIND OF BUSINESS OR INDUSTRY EMBROIDERY MFG.		11. BIRTHPLACE (State or foreign country) MARTINSBURG, W. VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROBERT M. ROSENBUSH		14. MOTHER'S MAIDEN NAME BINA WEINBERG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. GABRIEL W. ROSENBUSH, JR. 6803 CHIPPEWA DR.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RUPTURED PYLORIC ULCER		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CANCER OF LIVER AND CHEST WALL		(B) ? MONTHS.	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD, DIABETES, PARKINSONISM, URINARY INFECTION; PNEUMONIA		- 2 YRS. - 1 WEEK			
19A. DATE OF OPERATION 8-15-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED PYLORIC ULCER AND CA.		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from 8-15-72 to 8-21-72		that (we) last saw the deceased alive on 8-21-72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.	
23A. SIGNATURE Ronald P. Byank, M.D.		23B. DATE SIGNED 8-21-72		23C. PHYSICIAN'S NAME (Type) RONALD P. BYANK, M.D.	
23D. ADDRESS SINAI HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 8/22/72	
24C. NAME OF CEMETERY or CREMATORY LOUDON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 25 1972	
25B. NAME OF REGISTRAR Sidney H. [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		25D. ADDRESS 6010 REISTERSTOWN ROAD	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08117</b>	
72 08117				STATE OF MARYLAND-DEPT	
BIRTH NO. <b>H-200</b>				DEATH	
1. NAME OF DECEASED (Type or Print) <b>BERTHA HUSS</b>			2. DATE AND HOUR OF DEATH <b>AUGUST 21, 1972</b> <b>7:20 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>JEWISH CONVALESCENT HOME</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3541 PARK HEIGHTS AVENUE #21215</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 1888</b>		9. AGE (In years last birthday) <b>84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETAIL</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>MORRIS HUSS</b>			14. MOTHER'S MAIDEN NAME <b>BESSIE EHRLICK</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. ALBERT B. HUSS</b> ADDRESS <b>PARK TOWERS WEST, APT. 706 7121 PARK HEIGHTS AVE. #15</b>	
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH <b>Cerebral Thrombosis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 days.</b>
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7/28</b> 19 <b>72</b> to <b>8/21</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>8/17</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Albert Himelfarb</b> DEGREE				23B. DATE SIGNED <b>8/22/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALBERT HIMELFARB</b>			23D. ADDRESS <b>222 W. COLD SPRING LANE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>SHOMRA ADATH</b>	
24D. LOCATION (City, town, or county) <b>ROSEDALE, MARYLAND</b>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whorton</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	
ADDRESS					

100

RECEIVED  
MAY 1961

RECEIVED MAY 1961

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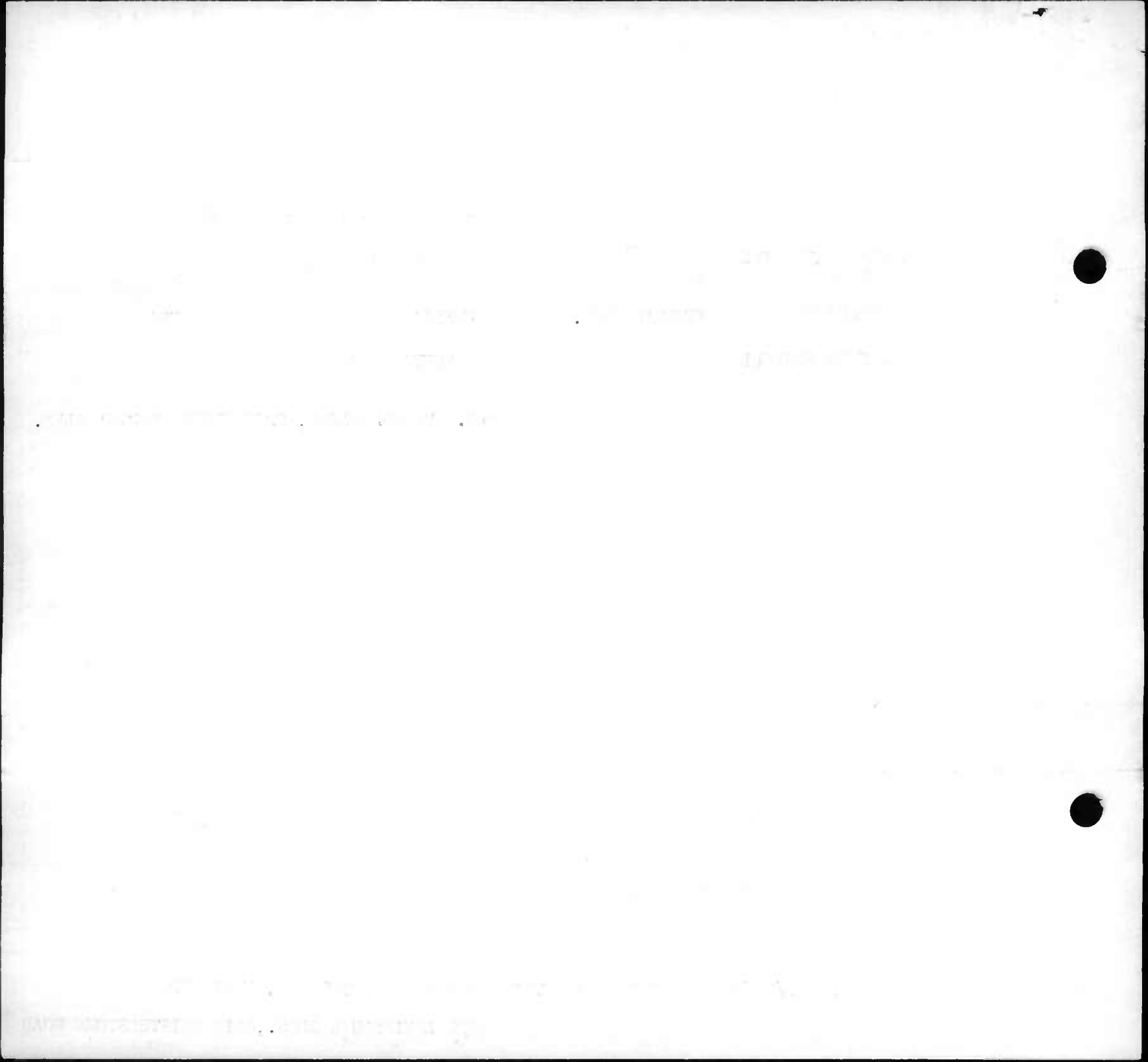
RECEIVED MAY 1961

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08118		72 08118	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND - <del>DEPT</del>	
1. NAME OF DECEASED (Type or Print) <u>Shargel, Julius</u>				2. DATE AND HOUR OF DEATH <u>8/20/72</u> <u>11:05</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2843</u>			
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/28/97</u>	
9. AGE (in years last birthday) <u>74</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>GENERAL MDSE.</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
13. FATHER'S NAME <u>JOSEPH SHARGEL</u>				14. MOTHER'S MAIDEN NAME <u>YETTA ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. DEBORAH BLANK, 5938 CROSS COUNTRY BLVD.</u>	
18. <u>4/2/21</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. HOW DID INJURY OCCUR?		21H. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> 19 <u>72</u> to <u>8/20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Karen M. Lichtenfeld MD</u>				23B. DATE SIGNED <u>8/20/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Karen M. Lichtenfeld MD</u>	
23D. ADDRESS <u>Sinai Hosp</u>				23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/22/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>BETH YEHUDA ANSHE KURLAND</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 25 1972</u>		25B. NAME OF REGISTRAR <u>Lidney</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS.</u>		25D. ADDRESS <u>6010 REISTERSTOWN ROAD</u>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08119		CERTIFICATE OF DEATH		REG. NO. 72 08119	
BIRTH NO. 6-635				STATE OF MARYLAND, DUMFRIES			
1. NAME OF DECEASED (Type or Print) <b>REBECCA GORDON (TAYLOR)</b>				2. DATE AND HOUR OF DEATH <b>AUG 21, 1972 6:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>General Convalescent Home 904601 Park Mall Rd Balt. Md 21215</b>				A. STATE <b>Ba</b> B. COUNTY <b>Maryland</b>			
				C. CITY OR TOWN <b>RANDALLSTOWN</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>9611 ORPIN ROAD #21133</b>			
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>XXXXXXXXXX</b> 9. AGE (In years last birthday) <b>95</b> <del>XXX</del>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RUBIN RUBENSTEIN</b>				14. MOTHER'S MAIDEN NAME <b>NORMA ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-20-77950</b>		17. INFORMANT <b>DAVE TAYLOR, 9611 ORPIN RD., APT. 202 #21133</b> ADDRESS			
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) <b>Arteriosclerotic Heart disease</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<b>6 years</b>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>no</b>			
				(C) <b>more</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 20</b> 19 <b>72</b> to <b>Aug 21</b> 19 <b>72</b> , that (I) <del>was</del> lost saw the deceased alive on <b>Aug 21</b> 19 <b>72</b> and that in (my) <del>your</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.							
23A. SIGNATURE <b>Manuel Levin MD</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8/21/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN MD</b>				23D. ADDRESS <b>6101 Park Hts Dr. Balt. Md 21215</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/22/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HEBREW ORTHODOX MEMORIAL SOCIETY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Sol Levinson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

STANDARD FORM NO. 64

EXHIBIT  
ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11/11/01 BY 60322 UCBAW

DATE 11/11/01 BY 60322 UCBAW  
EXHIBIT  
ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11/11/01 BY 60322 UCBAW

DATE 11/11/01 BY 60322 UCBAW

2/1/72  
ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11/11/01 BY 60322 UCBAW

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>L-100</b></span> <span><b>72 08120</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span> <b>72 08120</b>  <b>STATE OF MARYLAND-DHMH</b> </span> </div>			
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>Levy, Gertrude s.</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>Aug 22, 1972 1:38 P. M.</b>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MONTEBELLO STATE HOSPITAL</b> <b>91</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> <b>C. CITY OR TOWN</b> <b>Balto. Co. Md.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>4306 DANLOU DR.</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>8/2/12</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>AT HOME</b>	<b>9. AGE</b> (In years last birthday) <b>60</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>NEW YORK</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13. FATHER'S NAME</b> <b>JOSEPH GOLDES</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>LIZZY ?</b>	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>118-18-7913</b>	<b>17. INFORMANT</b> <b>MR. SOL LEVY, 4306 DANLOU DRIVE #21207</b> <b>ADDRESS</b>
<b>18. CAUSE OF DEATH</b> <div style="display: flex;"> <div style="flex: 1;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>            (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.         </div> <div style="flex: 1;"> <b>(A) IMMEDIATE CAUSE</b> <b>Astrocystoma</b>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Right Temporal lobe</b>  <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(C)</b> </div> <div style="flex: 0.5;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <b>2 mos.</b> </div> </div>			
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>			
<b>19A. DATE OF OPERATION</b> <b>0</b>	<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>	<b>20A. AUTOPSY?</b> (Yes or No) <b>NO</b>	<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>	<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)	<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from July 25 1972 to Aug. 22 1972 that (I) (we) last saw the deceased alive on Aug. 22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>			
<b>23A. SIGNATURE</b> <b>CORAZON M. CUEVAS, M.D.</b>		<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>	<b>23B. DATE SIGNED</b> <b>8-22-72</b>
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>CORAZON M. CUEVAS, M.D.</b>		<b>23D. ADDRESS</b> <b>Montebello State</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>	<b>24B. DATE</b> <b>8/23/72</b>	<b>24C. NAME of CEMETERY or CREMATORY</b> <b>OHR KNESSETH ISRAEL ANSHE SFARD</b>	<b>24D. LOCATION</b> (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>AUG 25 1972</b>	<b>25B. NAME OF REGISTRAR</b> <b>SOL LEVINSON</b>	<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

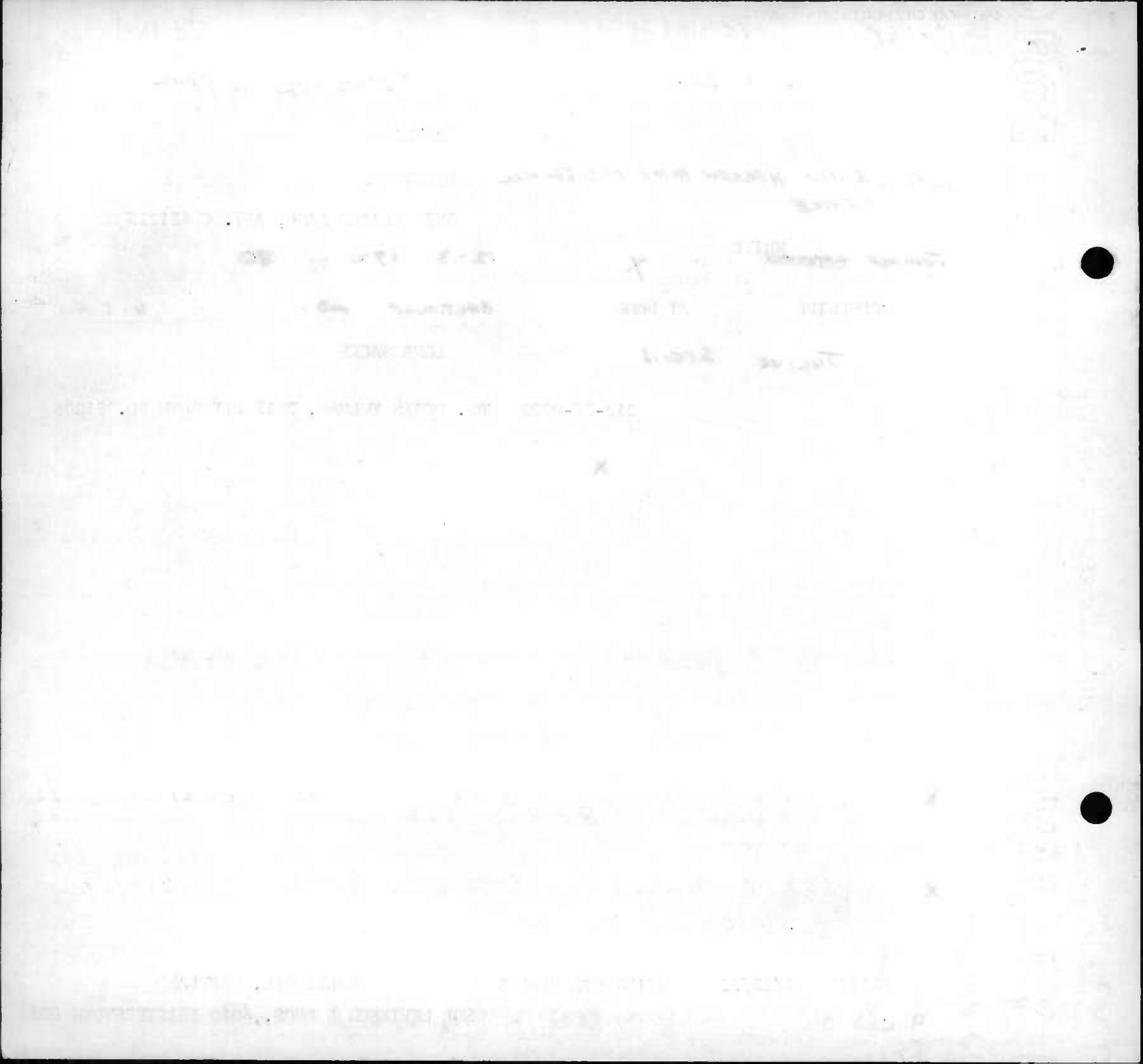
NO

118-18-2913 MR. SOL LEVY, 4306 DANLON DRIVE #21507

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08121</u>
72 08121				STATE OF MARYLAND-DEATH
B-200 BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <u>EDNA R. BASS</u>		2. DATE AND HOUR OF DEATH <u>8-21-72 @ 9pm</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>Levin dale HEBREW HOME AND GERIATRIC 91 CENTRE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3939 CLARKS LANE, APT. C #21215</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-1892</u>	9. AGE (In years last birthday) <u>79</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>JULIUS STEIN</u>		
14. MOTHER'S MAIDEN NAME <u>LENA SACKS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>212-26-0729</u>		17. INFORMANT <u>MRS. DORIS YULMAN, 7013 PLYMOUTH RD. #21208</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of ovary with metastases</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown duration</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>years?</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8-9</u> 19 <u>72</u> to <u>8-21</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>8-21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Soon Chul Hong</u>		23B. DATE SIGNED <u>8-21-1972</u>		23C. PHYSICIAN'S NAME (Type) <u>SOON CHUL HONG</u>
23D. ADDRESS <u>SOON CHUL HONG</u>		23E. FUNERAL DIRECTOR <u>SOI LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/23/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW</u>
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 25 1972</u>		
25B. NAME OF REGISTRAR <u>Andrey</u>		25C. FUNERAL DIRECTOR <u>SOI LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08122		72 08122	
H-630				72 08122		72 08122	
BIRTH NO.				72 08122		72 08122	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HARDY, Nellie D.				8/22/72 2:00 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
BON SECOURS HOSPITAL				Maryland 2005			
34				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				478 S. Bentalou St.			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female W				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		01-08-99 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Housewife						11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Foster Rautzahn				EMMA FRENCH		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				217-26-6308B		Mr. James R. Hardy, 478 S. Bentalou St. 21223	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CHF & Poss. pulmonary emboli			
ANTECEDENT CAUSES				(B) CHRONIC heart failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Involuntarily medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7-20-72 1972 to 22-8-1972 that (I) (we) lost saw the deceased alive on 8-23-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Whargave				8/22/1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr Schaffer				Bon Secours Hospital Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-25-1972		Loudon Park Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 25 1972		Howard H. Hubbard		Howard H. Hubbard		4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08123</b>
72 08123 CERTIFICATE OF DEATH				STATE OF MARYLAND - DHMH
BIRTH NO. <b>B-260</b>		1. NAME OF DECEASED (Type or Print) <b>RALPH A. BAKER</b>		
2. DATE AND HOUR OF DEATH <b>8/21/72</b>		3. TIME <b>3:25 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>FREDERICK</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GEN. HOSP.</b> <b>48 E. LINDEN AVE.</b> <b>BALTO., MD. 21201</b>		C. CITY OR TOWN <b>FREDERICK</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>Male</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/1900</b>		9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>MURRIS BAKER (220 10 5693)</b>		
14. MOTHER'S MAIDEN NAME <b>FANNIE ANNE MURPHY</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>212-10-5693</b>		17. INFORMANT <b>MRS. RICHARD BAKER</b>		
18. <b>5-19-51</b>		ADDRESS <b>Honey Brook PA.</b>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>RESPIRATORY ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Chronic obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>		
(C) <b>Aspiration Pneumonia</b> <b>few days</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ASCVD, CVD, Hypertension</b>				
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <b>August 18</b> 19 <b>72</b> to <b>Aug. 21</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>Aug. 21</b> 19 <b>72</b> and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED <b>8/21/72</b>		23C. PHYSICIAN'S NAME (Type) <b>R. M. ALCARAY</b>
23D. ADDRESS <b>827 LINDEN AVE., BALTO., MD.</b>		23E. NAME OF REGISTRAR <b>SMITH, FADELEY, KEENEY, BASFORD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/24/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mount Olivet Cemetery</b>
24D. LOCATION <b>Frederick Frederick Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		
25B. NAME OF REGISTRAR <b>SMITH, FADELEY, KEENEY, BASFORD</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SMITH, FADELEY, KEENEY, BASFORD FUNERAL HOME</b>		

1950

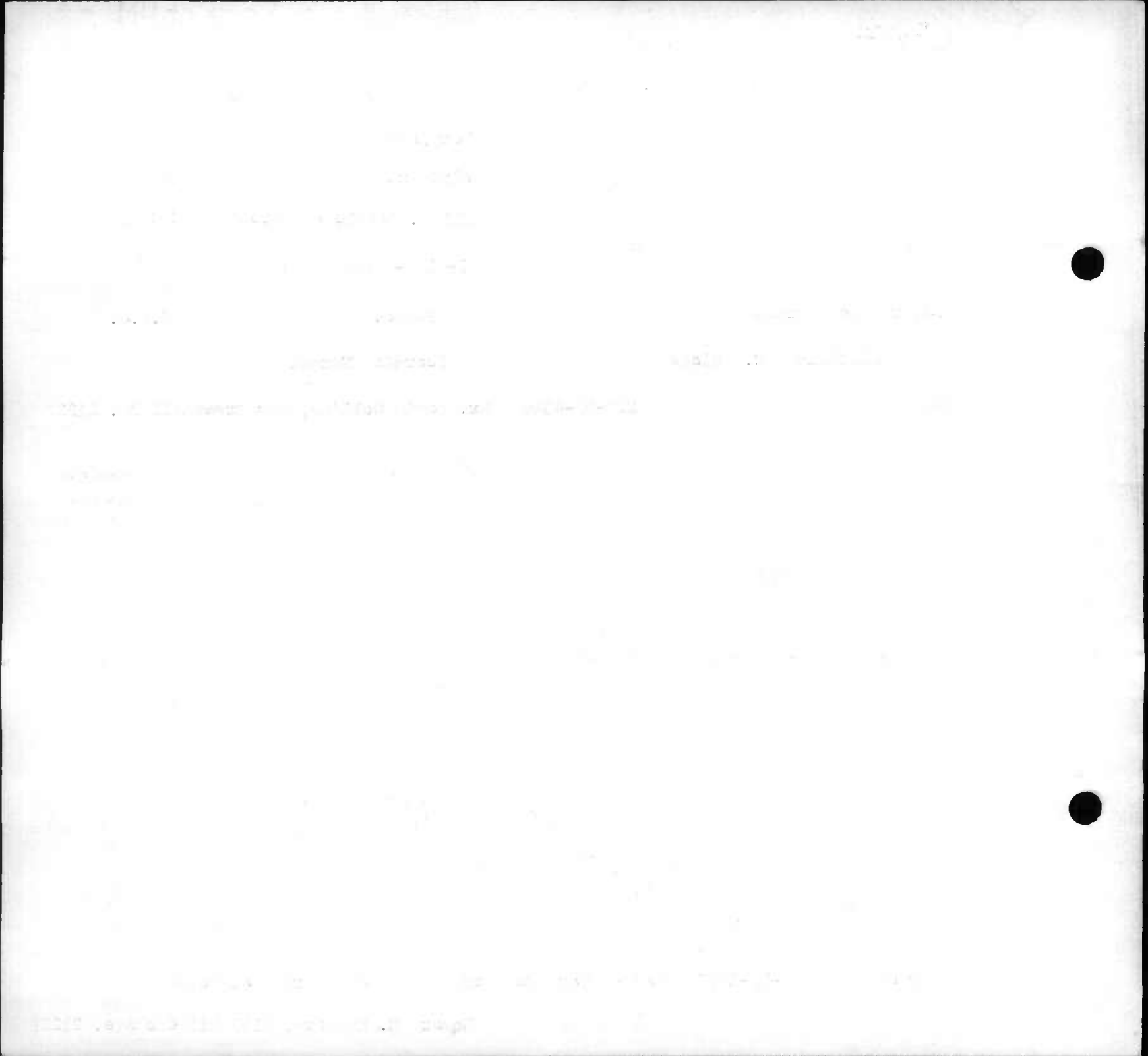
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-452		72 08124		BALTIMORE CITY HEALTH DEPARTMENT		72 08124	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND - DEPT. HEALTH	
1. NAME OF DECEASED (Type or Print) <i>Eugenia B. Collins</i>				2. DATE AND HOUR OF DEATH <i>21 August 72 3:35 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1803</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Maryland Hospital 38</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>133 S. Poppleton Street 21201</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-26-1903</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Seamstress</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Winfield G. Blake</i>				14. MOTHER'S MAIDEN NAME <i>Pearnia Turner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>218-03-6340</i>		17. INFORMANT ADDRESS <i>Mr. David Collins, 933 Grovehill Rd. 21227</i>		
18. <i>730.01</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Recurrent Subarachnoid Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Hypertension, CHF</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8/14</i> 19 <i>72</i> to <i>8/21</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8/21</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. H. Ziegler M.D.</i>				23B. DATE SIGNED <i>8/21/72</i>		23C. PHYSICIAN'S NAME (Type) <i>J. H. Ziegler M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-25-1972</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 25 1972</i>		25B. NAME OF REGISTRAR <i>Lidney W. Hubert</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		ADDRESS <i>4107 Wilkens Ave. 21229</i>	

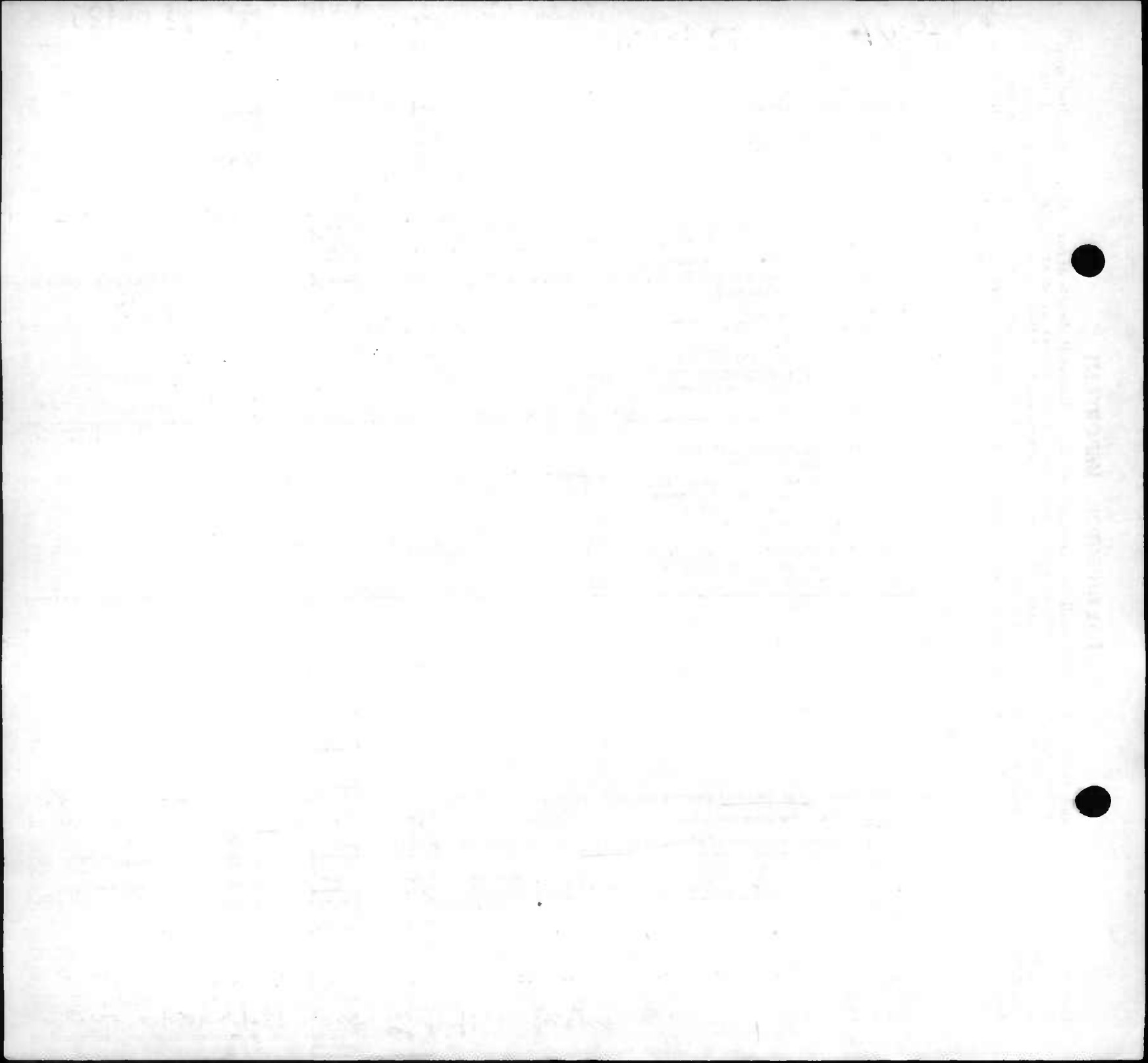


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08125	
72 08125 CERTIFICATE OF DEATH				REG. NO. 72 08125	
STATE OF MARYLAND-DHMH					
BIRTH NO. <u>H-241</u>		1. NAME OF DECEASED (Type or Print) <u>Haslup Marion H.</u>		2. DATE AND HOUR OF DEATH <u>8-23-72</u> <u>3:04</u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>702</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>742 N. Kenwood Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/01</u>		9. AGE (In years last birthday) <u>71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Blair B. Smith</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth V. Wendig</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>281 160563</u>		17. INFORMANT <u>Charles A. Gail</u> ADDRESS <u>624 N. Kenwood Ave.</u>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,					
(A) IMMEDIATE CAUSE <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) —					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>8/26/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> 19 <u>72</u> to <u>8/23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harry R. Jacobson M.D.</u>				23B. DATE SIGNED <u>8/23/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harry R. Jacobson, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-26-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 25 1972</u>		25B. NAME OF REGISTRAR <u>Adrienne Weston</u>		25C. FUNERAL DIRECTOR <u>Charles A. Gail</u> ADDRESS <u>124 Chesaco Ave.</u>	

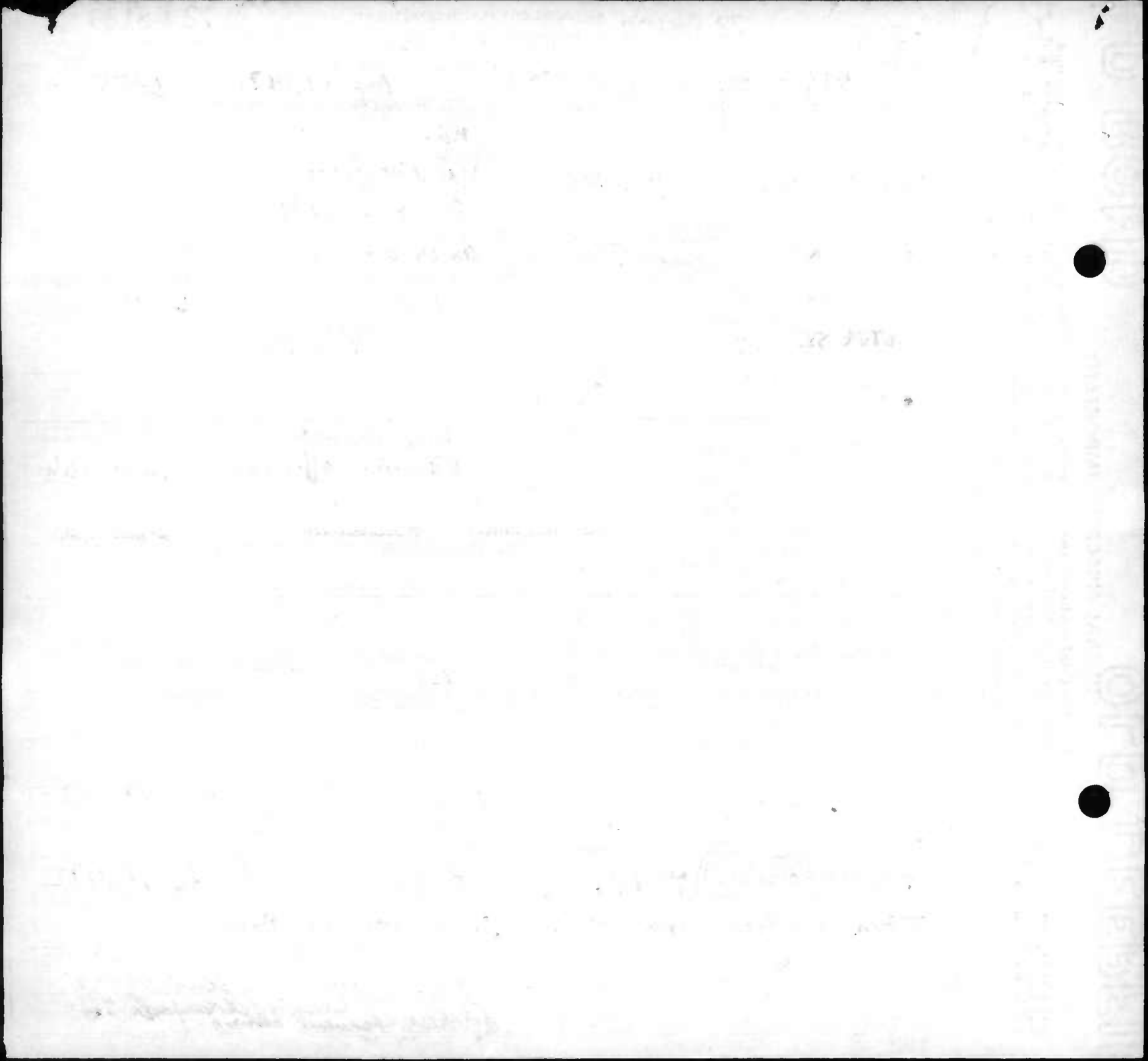




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

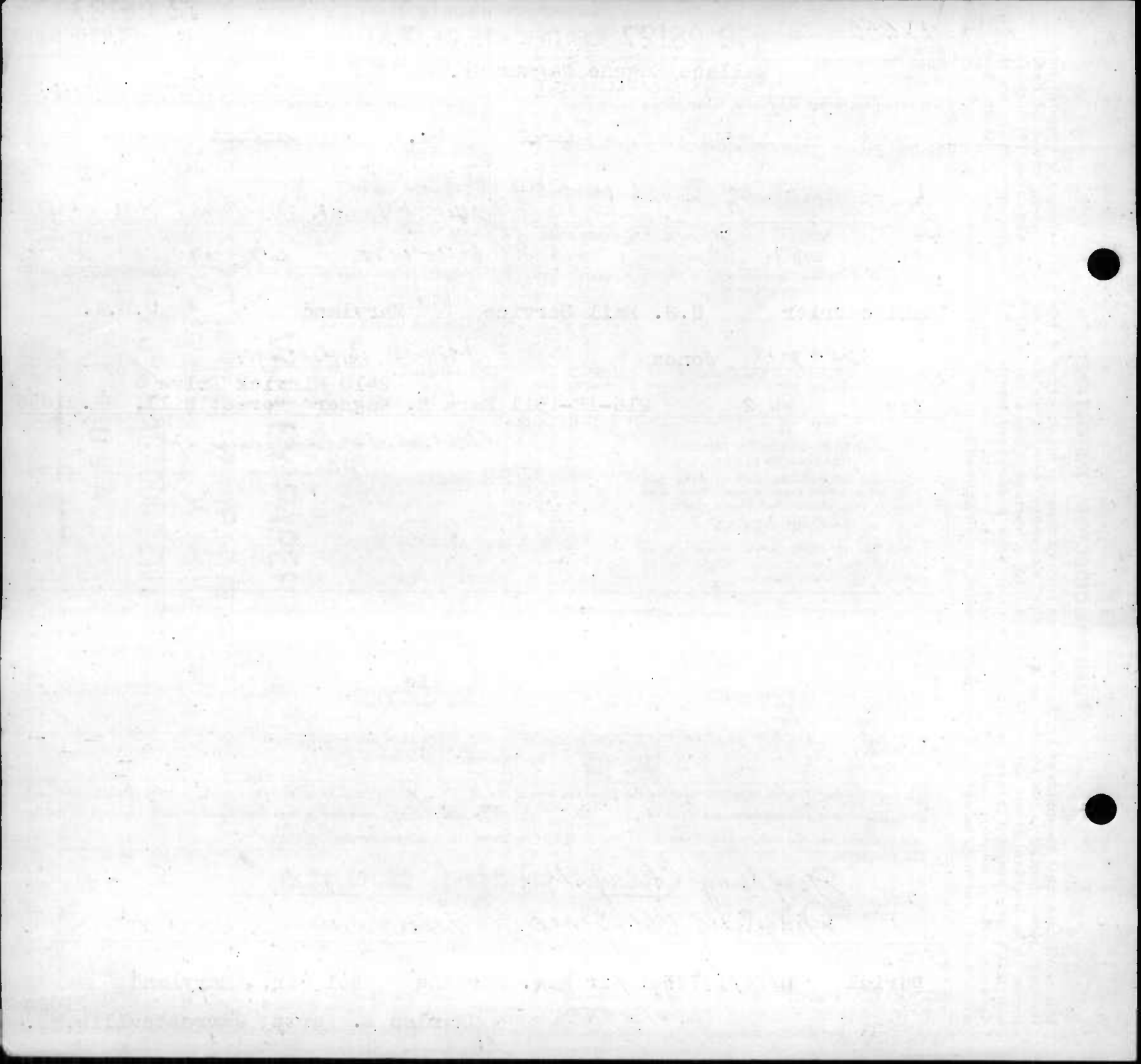
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08126	
BIRTH NO. S-363 72 08126		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <u>Wendy A Stewart</u>		2. DATE AND HOUR OF DEATH <u>Aug 17, 1972</u> <u>0605 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <u>md.</u> B. COUNTY <u>HARFORD</u> C. CITY OR TOWN <u>Harve De Grace</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>PO. Box 124</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06.04.67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>5</u> 11. Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min.
13. FATHER'S NAME <u>WALTER STEWART</u>		14. MOTHER'S MAIDEN NAME <u>SHERRY HATCH</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT ADDRESS
18. <u>189.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Lung metastases</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pleural effusion</u> <u>Within Tumour</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>several weeks</u> (B) <u>&gt; one year</u> (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 9</u> 19 <u>72</u> to <u>Aug 17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 17</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Teodoro Forchetti, M.D.</u>		23B. DATE SIGNED <u>Aug 19, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>TEODORO FORCHETTI - DOB M.D.</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>8/18/72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>London Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 25 1972</u>		25B. NAME OF REGISTRAR <u>Lidney W. H. H. H.</u>	
25C. FUNERAL DIRECTOR <u>Harvey Funeral Home</u>		25D. ADDRESS <u>19</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

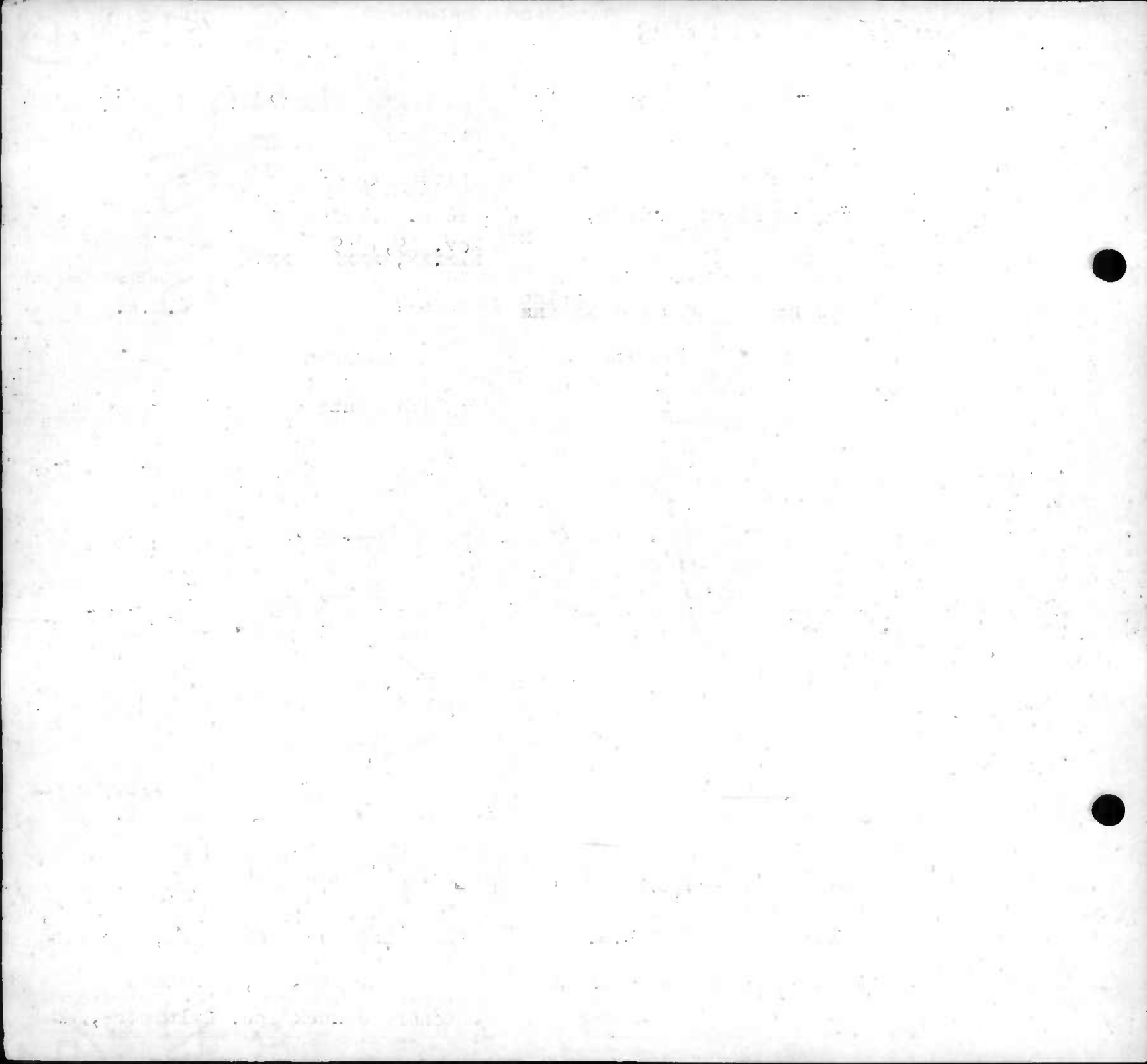
BALTIMORE CITY HEALTH DEPARTMENT				72 08127
72 08127 CERTIFICATE OF DEATH			REG. NO. <span style="border: 1px solid black; padding: 2px;">72 08127</span>	
1. NAME OF DECEASED (Type or Print) <i>Wallace Eugene Wagner Sr.</i>		2. DATE AND HOUR OF DEATH <i>Aug. 23. 2:20 PM. 1972. P. M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>South Baltimore General Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Harford</i>		
5. SEX <i>M.</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mail carrier</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>U.S. Mail Service</i>		8. DATE OF BIRTH <i>6-21-1925</i>
13. FATHER'S NAME <i>Seafers Jones</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Puffenberger</i>		9. AGE (In years last birthday) <i>47</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>WW 2 216-18-1511</i>		11. BIRTHPLACE (State or foreign country) <i>Md. Maryland</i>
17. INFORMANT <i>Sara M. Wagner</i>		ADDRESS <i>2410 Minnick Drive Forest Hill, Md. 21050</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
18. <i>157.9 I</i> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Metastatic Carcinoma of Pancreas</i>				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>8-7</i> 19 <i>72</i> to <i>8-23</i> 19 <i>72</i> , that (I) (we) lost saw the deceased alive on <i>8-23</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Gong Sung Chang, M.D.</i>				23B. DATE SIGNED <i>8-23-72</i>
23C. PHYSICIAN'S NAME (Type) <i>Gong Sung Chang M.D.</i>		23D. ADDRESS <i>South Baltimore General Hospital.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/26/1972</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bel Air Mem. Gardens</i>
24D. LOCATION <i>Bel Air, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 25 1972</i>		
25B. NAME OF REGISTRAR <i>Dudley S. Hinton</i>		25C. FUNERAL DIRECTOR <i>Charles E. Kurtz</i>		
ADDRESS <i>21084 Jarrettsville, Md.</i>				



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<p><b>H-525</b>      <b>72 08128</b>      <b>CERTIFICATE OF DEATH</b></p>		<p>BIRTH NO.      <b>72 08128</b></p>	
<p>1. NAME OF DECEASED (Type or Print)      <b>Niels Christian Hansen</b></p>		<p>2. DATE AND HOUR OF DEATH August 23, 1972      9:40 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION      (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>70</b> House In The Pines (Belair)</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE      B. COUNTY Maryland      1102</p>	
<p>5. SEX      6. RACE      7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Male      Cauc      WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH      9. AGE (In years and months) Nov 29, 1889      83 82</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seaman</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine</p>	
<p>11. BIRTHPLACE (State or foreign country) Denmark</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME ? Hansen</p>		<p>14. MOTHER'S MAIDEN NAME Unknown</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes</p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT Mrs Elsie Butz 6829 Old Harford Rd</p>		<p>ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH <b>Anteriorly Heart Disease</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —</p>	
<p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, having rise to the above cause (2) and the UNDERLYING CONDITION last  II Old Myocardial Infarction Old Stroke &amp; hypertension &amp; atherosclerosis Past - 7. Fracture of left hip — 3 weeks</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) —</p>	
<p>19A. DATE OF OPERATION      19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)      20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No</p>	
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (the hospital) attended the deceased from 8/24/72 to 8/23/72, that (I) (we) last saw the deceased alive on 8/24/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Albert B Bradley</p>		<p>23B. DATE SIGNED 8/24/72</p>	
<p>23C. PHYSICIAN'S NAME (Type) Albert B Bradley M.D.</p>		<p>23D. ADDRESS 4900 Belair Rd Baltimore, Maryland</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Cremation</p>		<p>24B. DATE 8/24/72</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Greenmount</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. AUG 25 1972</p>		<p>25B. NAME OF REGISTRAR Sidney J. Ruck</p>	
<p>25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Md</p>		<p>ADDRESS</p>	

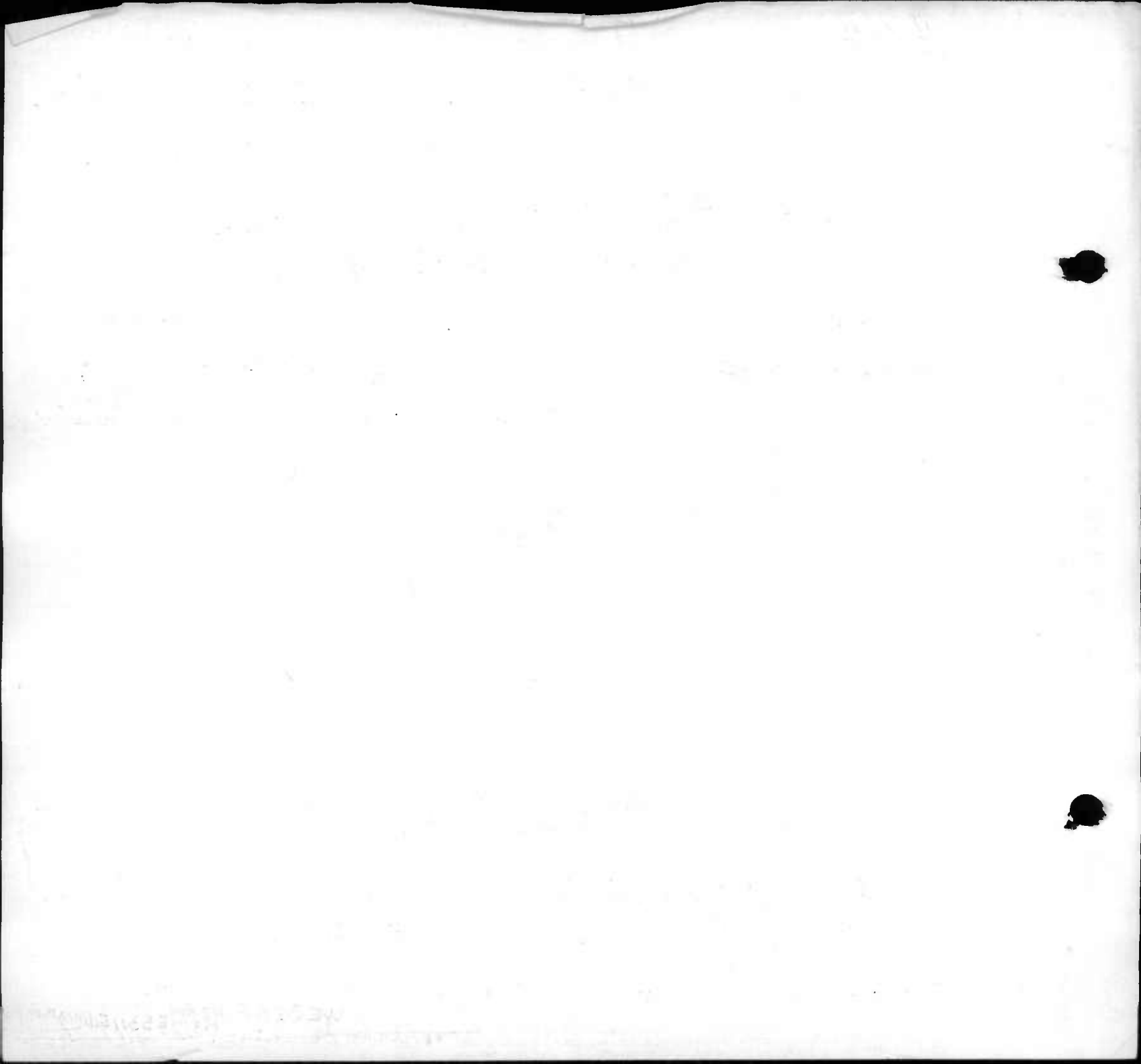




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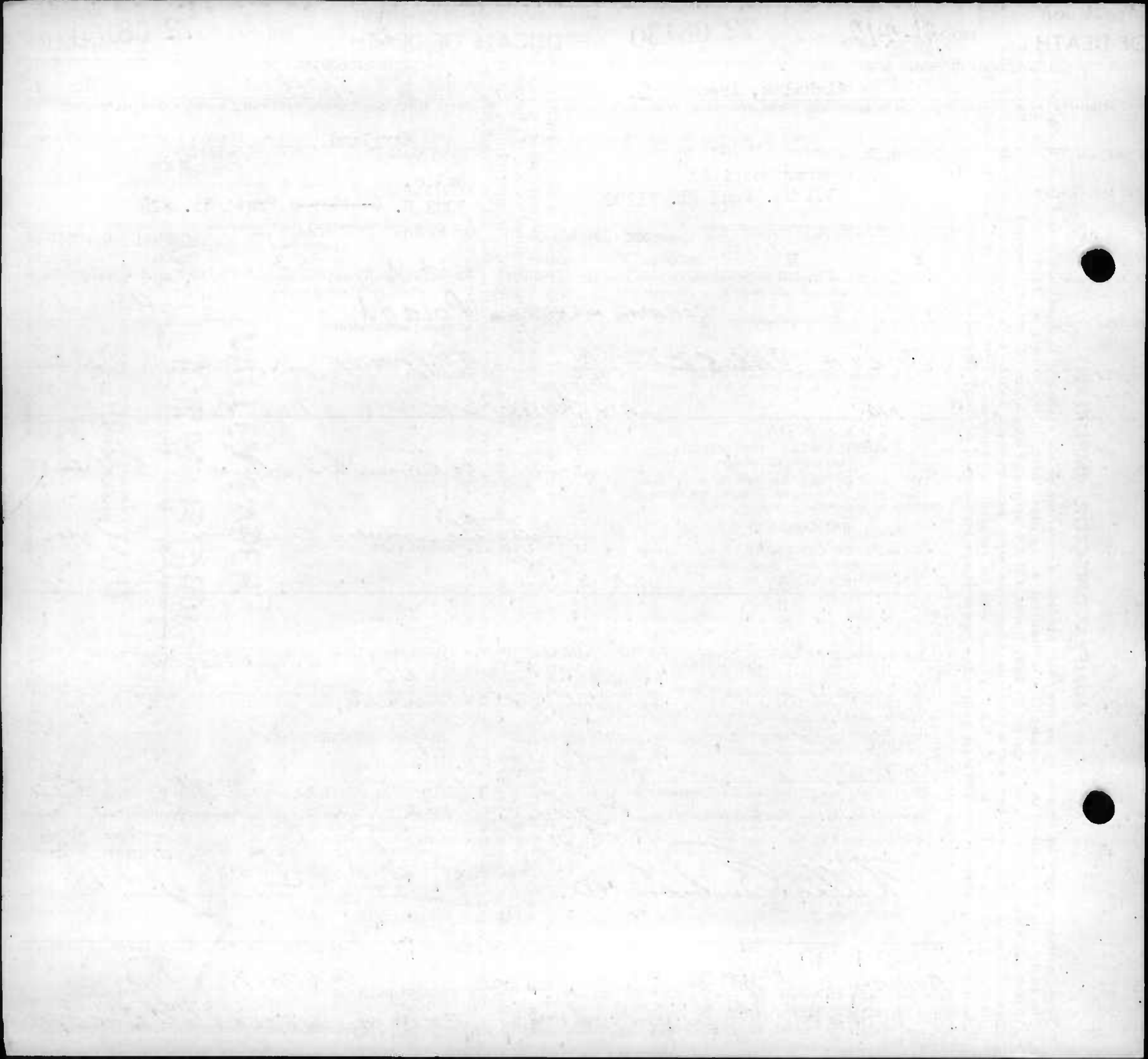
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
4-612		72 08129		72 08129	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - DEATH	
Bessien, Herbert		8-23-72 735 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Lincoln Nursing Home			Crowsville State Hospital		
27 W. Carey St			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Baltimore County YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			E. STREET AND NUMBER		
F W			624 COLERAINE RD. 5300		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			8. DATE OF BIRTH 9. AGE (in years lost birthday)		
RETIRED			4-27-1891 81		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
			MD		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
JOSEPH CADLE			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			217-18-6370		
17. INFORMANT			ADDRESS		
MINNIE ALBERT			624		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
I					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7-27-1972 to 8-23-1972 that (I) (we) last saw the deceased alive on 8-23-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
A. I. Baykaler, M.D.			8-23-72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
A. I. Baykaler, M.D.			301 Mc Mechen St.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		8-26-72		BALTO. CEMETERY BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 25 1972		Dwight Whitman		WEBER FUNERAL HOME 5312 E. Pratt St.	



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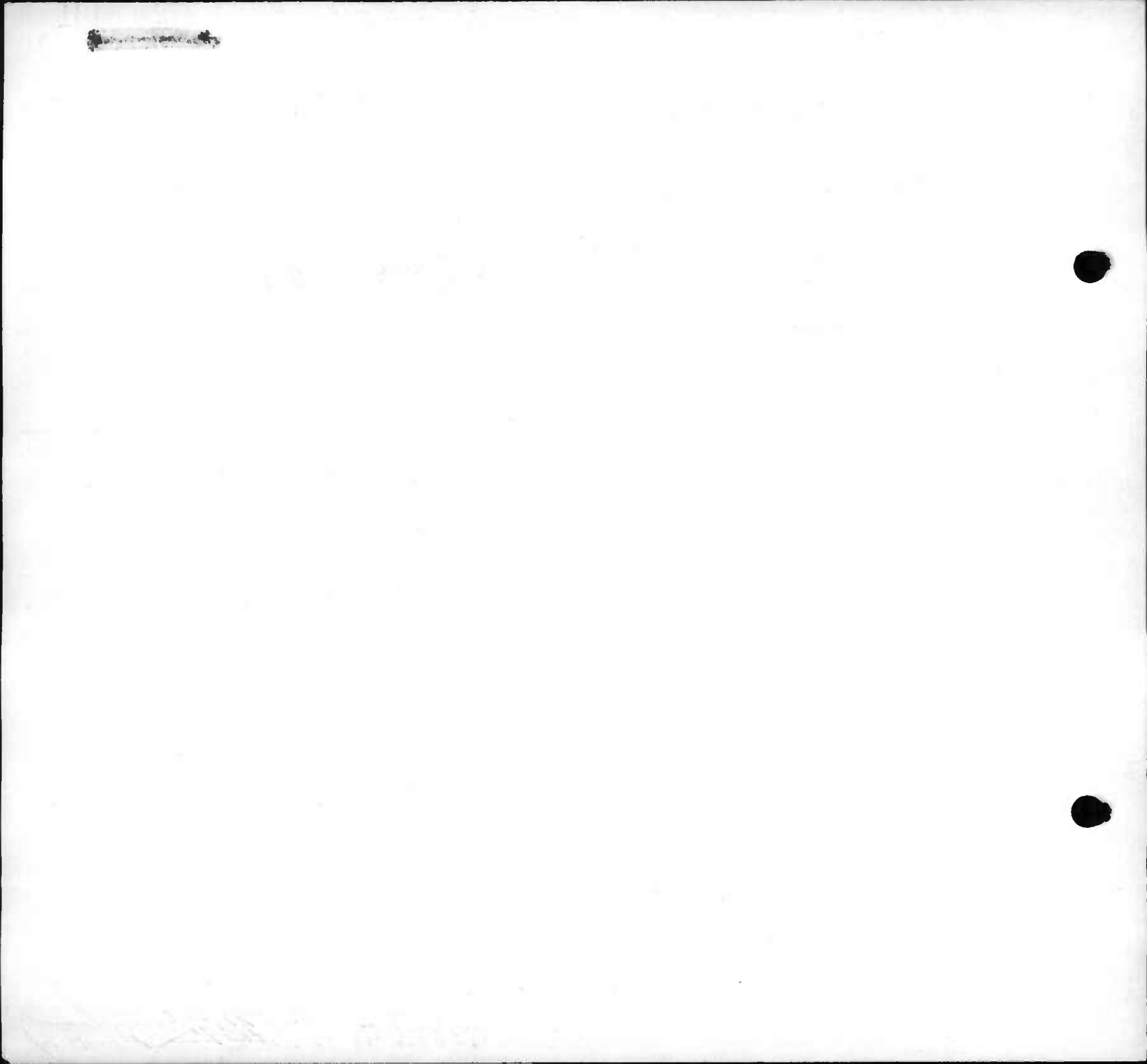
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08130	
M-242 72 08130				STATE OF MARYLAND-DHMH	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Michalak, Irene S.</b>			2. DATE AND HOUR OF DEATH <b>8/24/72 2:30 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>37 Mercy Hospital 301 St. Paul Pl. 21202</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>102</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3002 E. Baltimore Pratt St. #24</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-22-18</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>CORMAN &amp; WASSERMAN</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
13. FATHER'S NAME <b>JOSEPH JAROCZEWSKI</b>			14. MOTHER'S MAIDEN NAME <b>JOSEPHINE KACZKOWICZ</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-30-5880</b>		17. INFORMANT <b>CASIMIR MICHALAK</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>183.0 I</b> <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>± 48 hrs</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>cardiac valve</b> (B) <b>metastatic ovarian carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF: <b>~ 2 yrs</b> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/20</b> 19 <b>72</b> to <b>8/24</b> 19 <b>72</b> , that (I) (we) lost saw the deceased olive on <b>8/24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William B. ... MD</b>				23B. DATE SIGNED <b>8/24/72</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>BURIAL</b>		<b>8-28-72</b>		<b>HOLY ROSARY</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>AUG 25 1972</b>		<b>Sidney ...</b>		<b>FOR M. M. WEBER &amp; SONS CHESTER</b>	



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BALTIMORE CITY HEALTH DEPARTMENT				72 08131		REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
BIRTH NO. <span style="font-size: 1.5em;">S-134</span>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Spadley - Roger				8-24-72 6:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
Bolton Hill Nursing Home				MD - 1603			
90				E. STREET AND NUMBER			
827 No. Fulton Ave. 2-223				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
M		B		- 8-30-97		9. AGE (In years last birthday)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		Unknown		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				225-246934		R. Dominini Chert	
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CA prostate with metastasis							
(B) DUE TO, OR AS A CONSEQUENCE OF: antenatal kidney disease							
(C) DUE TO, OR AS A CONSEQUENCE OF: antenatal generalized							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
1 year							
years							
years							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		0		No		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 8/22 1972 to 8/24 1972 that (I) (we) last saw the deceased alive on 8/24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
[Signature]				8/24/72		Dr. H. M. [Signature]	
23D. ADDRESS				24A. BURIAL CREMATION, REMOVAL (Specify)			
2500 Read St. Baltimore, MD				Burial 8/30/72 Mt. Auburn			
24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
8/30/72				Baltimore Md			
24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT.			
Baltimore Md				AUG 25 1972			
25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
[Signature]				[Signature]			
25D. ADDRESS				25E. ADDRESS			
[Signature]				[Signature]			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT

72 08132 CERTIFICATE OF DEATH

REG. NO.

72 08132

B-000  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

Lucinda Lee

2. DATE AND HOUR OF DEATH

8-20-1972

9

M.

STATE OF MARYLAND-DHMH

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Ave.

Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

124 Siegart Lane

21229

5. SEX

Female

6. RACE

Negro

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8/29/25

9. AGE (In years  
last birthday)

46

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Martin  
Kyle

14. MOTHER'S MAIDEN NAME

Josephine Wilson  
Dorine

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

John C. Lee

ADDRESS

18. 1972

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

Metastatic Adenocarcinoma

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

5 Mo

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

5 19 72 to

8/20 19 72

that (I) (we) last saw the deceased alive on

8/20 19 72

and that (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Robert L. Ruxin

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

8/20/72

23C. PHYSICIAN'S  
NAME (Type)

Robert L. Ruxin

23D. ADDRESS

4940 Eastern Ave. Baltimore, Md. 21224  
Baltimore City Hospitals24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

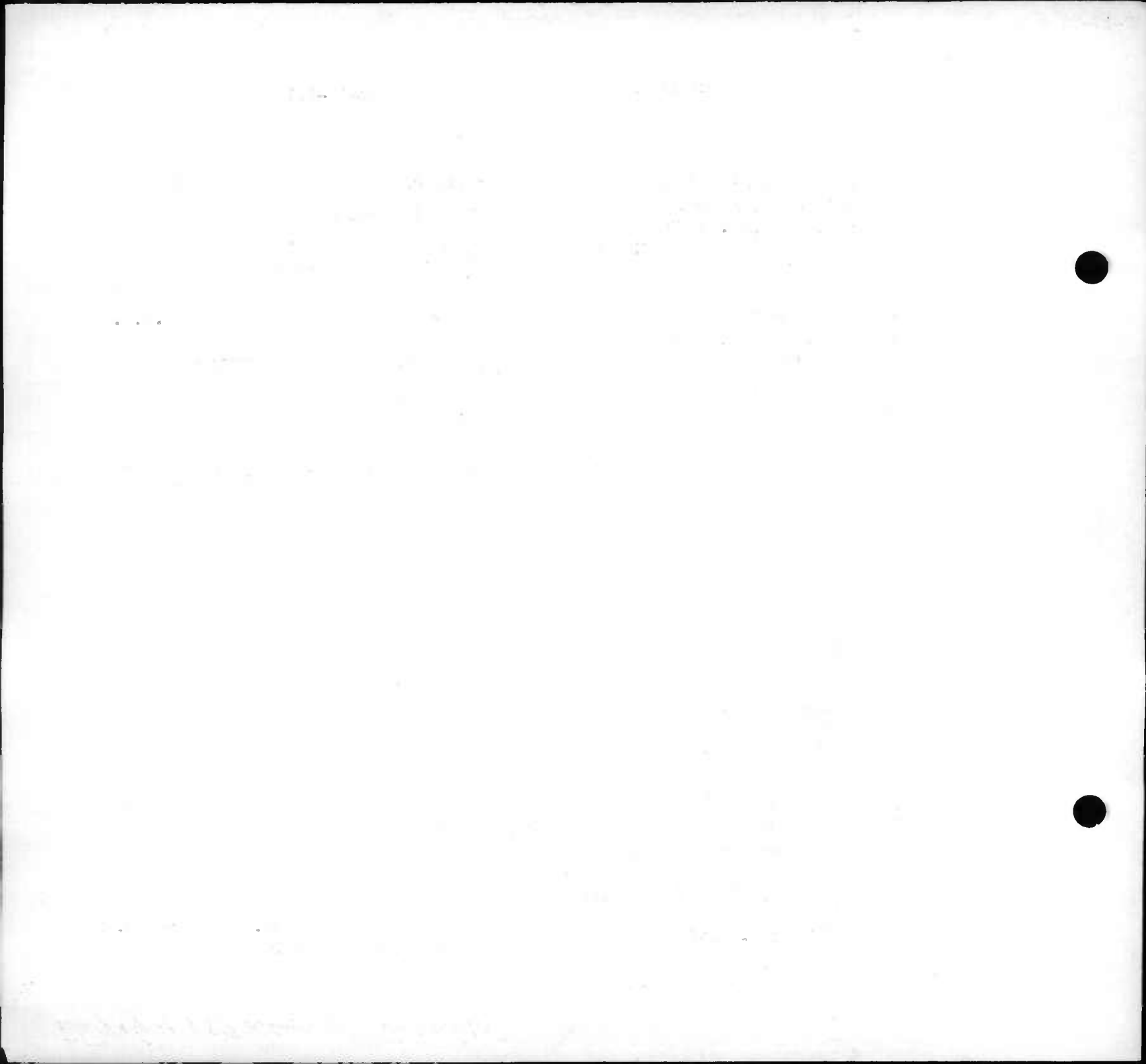
AUG 25 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

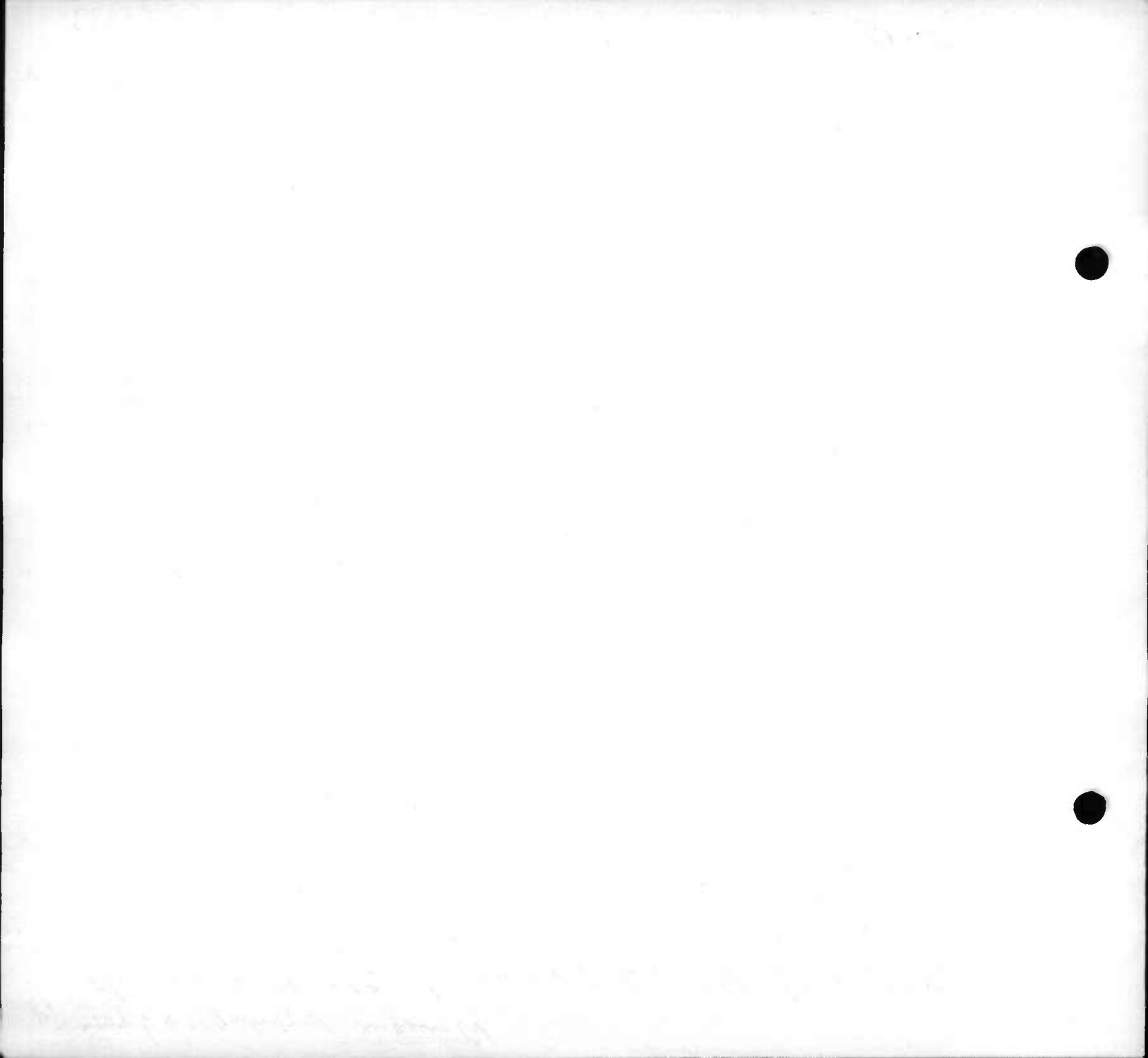




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08133		72 08133	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DIME	
1. NAME OF DECEASED (Type or Print) <b>MR. ARTHUR C. DUBLIN</b>		2. DATE AND HOUR OF DEATH <b>8/18/72</b>		2 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 BON SECOURS HOSP</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2001</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1822 N. LEXINGTON ST</b>			
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/7/17</b>	9. AGE (in years last birthday) <b>55</b>	If Under 1 Yr. Months: <b>1</b> Days: <b>1</b>	If Under 24 Hrs. Hours: <b>1</b> Min. <b>1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>CHARLES DUBLIN</b>				14. MOTHER'S MAIDEN NAME <b>KATE POWELL</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>218-10-9813</b>		17. INFORMANT <b>MRS. DUBLIN WIFE</b>		ADDRESS <b>AS ABOVE</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Crossing heart failure</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>AS CVD</b> <b>Uremia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>renal shutdown</b> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William P. Jones MD</b>				23B. DATE SIGNED <b>8-18-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>William P. Jones MD</b>				23D. ADDRESS <b>BON SECOURS HOSPITAL</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burned 8/20/72</b>		24B. DATE <b>8/20/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>CLONBURN MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Adrian Wharton</b>		25C. FUNERAL DIRECTOR <b>James P. Adams 638 S. Johns St</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>12 08134</span> <span>B-625</span> <span>72 08134</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 72-8134</span> </div> <div style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT</div>			
1. NAME OF DECEASED (Type or Print) <u>Florence Breckenridge</u>		2. DATE AND HOUR OF DEATH <u>8-18-72</u> <u>7.33 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore City</u> - <u>1703</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Kenson Nursing Home</u> <u>90 2922 Arundel Ave</u>		C. CITY OR TOWN <u>Baltimore</u>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2922 Arundel Ave.</u>	
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1903</u>
		9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-56-2847</u>	17. INFORMANT <u>Evelyn Banks - Same</u>
18. <u>410.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Prob Myocardial Inf.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Senility</u>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>104 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Feb 1972</u> 19 to <u>July 1972</u> 19 that (I) (we) last saw the deceased alive on <u>July 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(the hospital)</u> (did not) view the body after death.			
23A. SIGNATURE <u>Federico S. Cortes</u>		23B. DATE SIGNED <u>8-18-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Federico G. Arthes</u>		23D. ADDRESS <u>25 Cedar Ave Towson 4</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/2/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>MT Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 25 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Weston</u>	
25C. FUNERAL DIRECTOR <u>Theresa P. Hayes</u>		ADDRESS <u>630 N 9th St</u>	

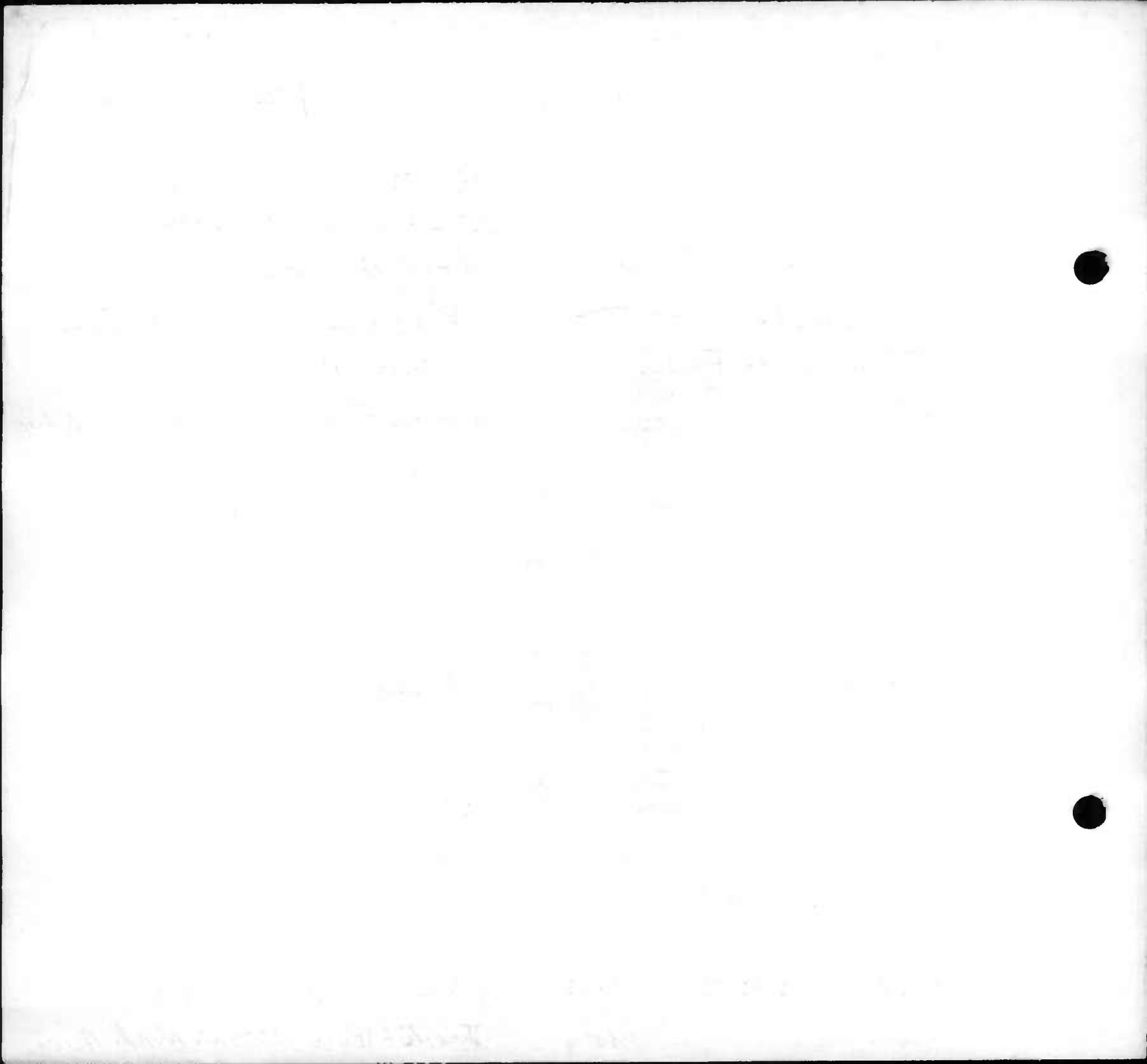
2/24/69

1306 Argyle Ave. 21217

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">I-630</h2>		<h2 style="margin: 0;">72 08135</h2>		<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2>		<h2 style="margin: 0;">72 08135</h2>	
<h3 style="margin: 0;">BIRTH NO.</h3>		<h3 style="margin: 0;">72 08135</h3>		<h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		<h3 style="margin: 0;">REG. NO.</h3>	
1. NAME OF DECEASED (Type or Print) <b>MARTHA FORD</b>				2. DATE AND HOUR OF DEATH <b>8/24/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland Hosp</b> <b>38</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Balto.</b> B. COUNTY <b>md</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2327 W North Ave 1503</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-18</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>	
13. FATHER'S NAME <b>James A. Ford</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Miller</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Martha Ford</b>		ADDRESS <b>2501 W. North Ave</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METASTATIC BREAST CARCINOMA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8-21-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ABOVE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8-20-72</b> 19__ to <b>8-24-72</b> 19__ that (I) (we) last saw the deceased alive on <b>8-24-72</b> 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <b>J. Gerard Crowley M.D.</b>				23B. DATE SIGNED <b>8-24-72</b>		23C. PHYSICIAN'S NAME (Type) <b>J. Gerard Crowley</b>	
23D. ADDRESS <b>2501 W. North Ave</b>				23E. DEGREE <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-28-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balt., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Anthony J. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Joseph L. [Signature]</b>		ADDRESS <b>2522 W. North Ave</b>	





## 72 081 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08136

BIRTH NO. MARYLAND DEPT. OF HEALTH &amp; MENTAL HYGIENE

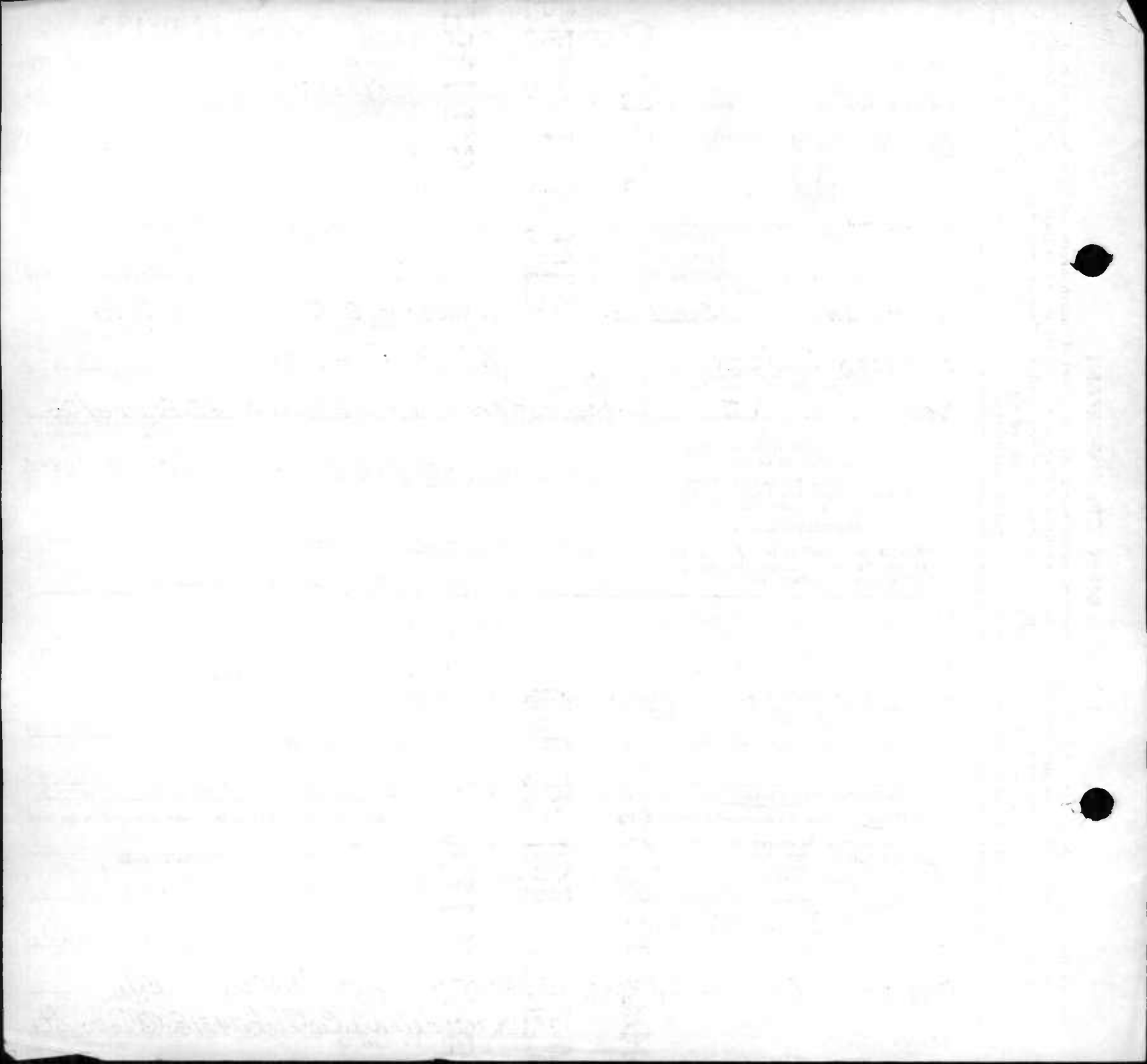
1. NAME OF DECEASED (Type or Print) <b>WILLIE LAMONT JONES</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 19 72 1:45 A.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>925 Bethune Rd.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 19 72 1:45 A.M.			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>7-29-1951</b>				10. AGE (In years last birthday) <b>21</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Willie Jones</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				15. MOTHER'S MAIDEN NAME <b>VIOLA BURTON</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				17. SOCIAL SECURITY NO.		18. INFORMANT <b>VIOLA B. JONES 875 BETHUNE ROAD</b>	
19. <b>E 966X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Stabwound of Neck DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street 925 Bethune Rd.</b>			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>8 19 72 1:30 a.m.</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>925 Bethune Rd.</b>				22F. HOW DID INJURY OCCUR? <b>Stabbed by unknown assailant</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/19/72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-23-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MOUNT RABURN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Johnston</b>		25C. FUNERAL DIRECTOR <b>Randolph J. Collick 2431 E. Oliver St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08137	
BIRTH NO. 72 08137 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>ELLISON, WILLIAM Henry</b>			2. DATE AND HOUR OF DEATH <b>8/22/72 8 AM</b> <sup>32</sup> <b>833</b> <sup>A</sup> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>843</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2914 E. FEDERAL STREET</b>	
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-31-16</b>	9. AGE (In years last birthday) <b>56</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stockman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>WINNSBORO, S. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Preston Ellison</b>		14. MOTHER'S MAIDEN NAME <b>Willie JOHNSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>249-03-2037</b>		17. INFORMANT <b>Mrs. Ella Mae Ellison 2914 E. Federal St.</b>	
18. <b>250.91</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>3 WEEKS</b>	
		(B) <b>DIABETES MELLITUS</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Mucormycosis</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/15/72</b> 19 <b>72</b> to <b>8/22</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John W. Kraus M.D.</b>				23B. DATE SIGNED <b>8/22/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John W. KRAUS</b>				23D. ADDRESS <b>601 N. BROADWAY, BALTO., MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-26-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION <b>BALTIMORE, Md.</b>		24E. NAME of REGISTRAR <b>Andrey Johnston</b>		24F. FUNERAL DIRECTOR <b>Randolph J. Collick 2431 E. Oliver St.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME of REGISTRAR <b>Andrey Johnston</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ERICA GREEN

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

4:25 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3807 Bonner Rd.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

4:25 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

6. SEX

female

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore City

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

3/24/1972

10. AGE (In years  
lost birthday)11. Under 1 Yr. 12 Under 24 Hrs.  
Months Days Hours Min.

4

E. STREET AND NUMBER

3807 Bonner Rd.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William A. Green, Jr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Infant

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Loretta Green

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

-0-

18. INFORMANT

Mrs. Loretta Green

ADDRESS

2546 Oswego Avenue

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Down's Syndrome  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/20/72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/23/72

24C. NAME OF CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

AUG 25 1972

25B. NAME OF REGISTRAR

Lidney W. Houston

25C. FUNERAL DIRECTOR

MORTON &amp; DYETT F.H.

ADDRESS

1701 Laurens St.

x

27/11/72

Director, Ceylon

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Director, Ceylon

Int. nt

Director, Ceylon

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72 08139

BALTIMORE CITY HEALTH DEPARTMENT

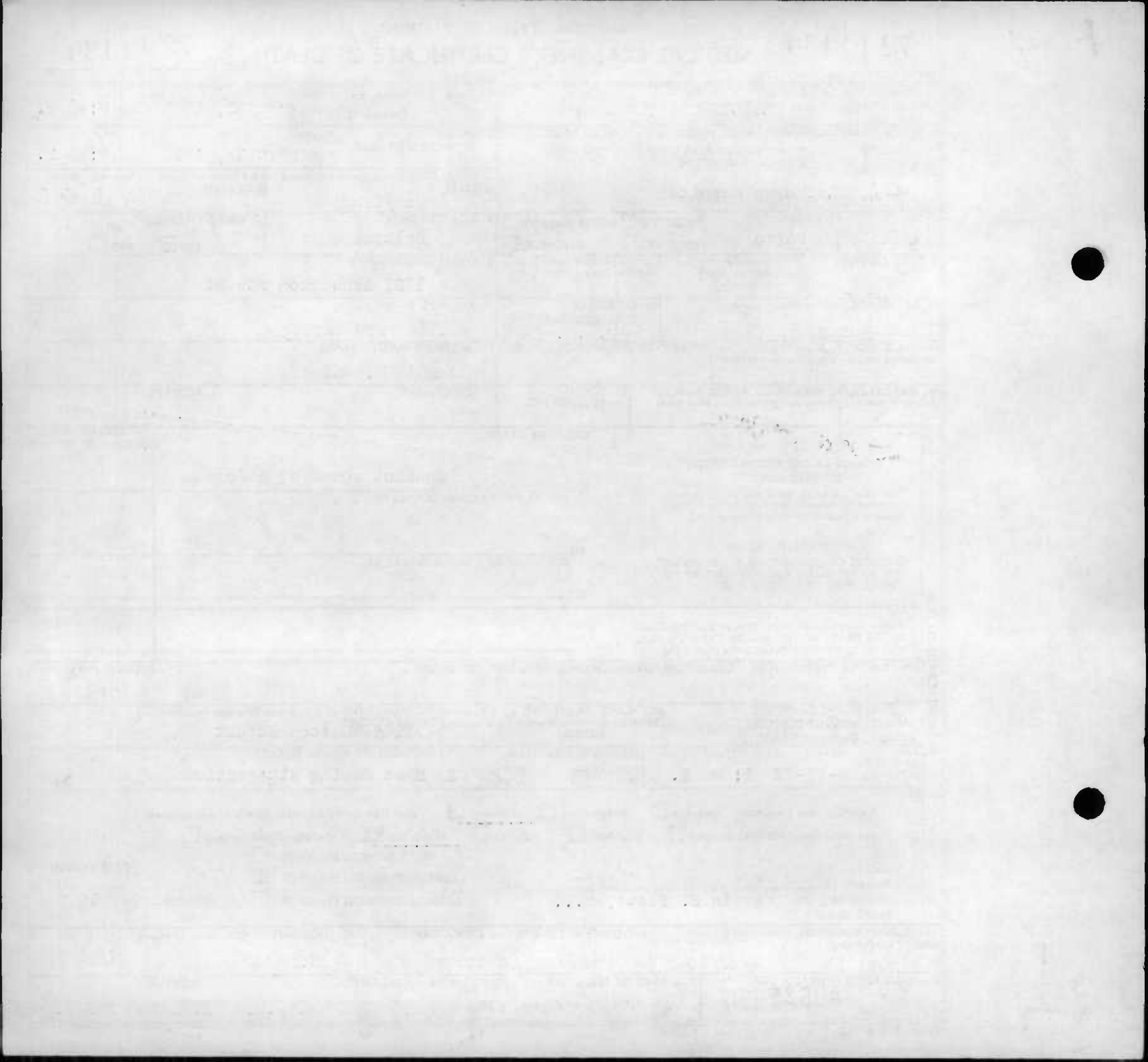
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08139

REG. NO.

BIRTH NO. STATE OF MARYLAND - DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) CHARLES BREEDLOVE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year August 23, 1972 Estimated <input type="checkbox"/> Hour 9:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year August 23, 1972 Hour 9:45 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-3-39		10. AGE (In years last birthday) 33	
11. BIRTHPLACE (State or foreign country) Tallahassee, Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Johnnie M. Palmer	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Gloria Breedlove		ADDRESS 1339 W. North Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunsight wound of abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 8-17-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8-17-72 1:00 P. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1721 Ashburton Street		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Marvin S. Platt, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: August 24, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/28/72	
24C. NAME OF CEMETERY or CREMATORY Greenwood Cemetery		24D. LOCATION (City, town, or county) (State) Tallahassee, Florida	
25A. DATE REC'D BY HEALTH DEPT. AUG 25 1972		25B. NAME OF REGISTRAR Audrey B. Horton	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	





A-620

72 08140

BALTIMORE CITY HEALTH DEPARTMENT

72 08140

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. STATE OF MARYLAND - DEATH

1. NAME OF DECEASED (Type or Print) <b>William H. Ayers</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 22 72</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 22 72 11:20 p.</b> M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2802</b>				C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		E. STREET AND NUMBER <b>5207 Bosworth Avenue</b>			
9. DATE OF BIRTH <b>2-28-37</b>		10. AGE (In years last birthday) <b>35</b>		11. BIRTHPLACE (State or foreign country) <b>ANDERSON, SOUTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES NOV 3, 58-62</b>				17. SOCIAL SECURITY NO. <b>250-52-8970</b>		15. MOTHER'S MAIDEN NAME <b>ANNIE WHEELER</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES NOV 3, 58-62</b>				17. SOCIAL SECURITY NO. <b>250-52-8970</b>		18. INFORMANT ADDRESS <b>REV. WILLIE AYERS 5207 BOSWORTH</b>	
19. I-965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH <b>Gunshot wound to chest with perforation of heart</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>STREET</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>4700 blk. of Gwynn Oak Avenue 2802</b>			
22D. TIME OF INJURY (APPROX.) <b>8 22 72 11:02 p.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot by unknown assailant.</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/23/72</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-28-72</b>		24C. NAME of CEMETERY or CREMATORY <b>GARDEN OF ETERNAL HOPE</b>		24D. LOCATION (City, town, or county) (State) <b>FINKSBURG, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Houston</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT FUNERAL HOME 1701 LAURENS ST.</b>			

120 ST

120 ST

120 ST

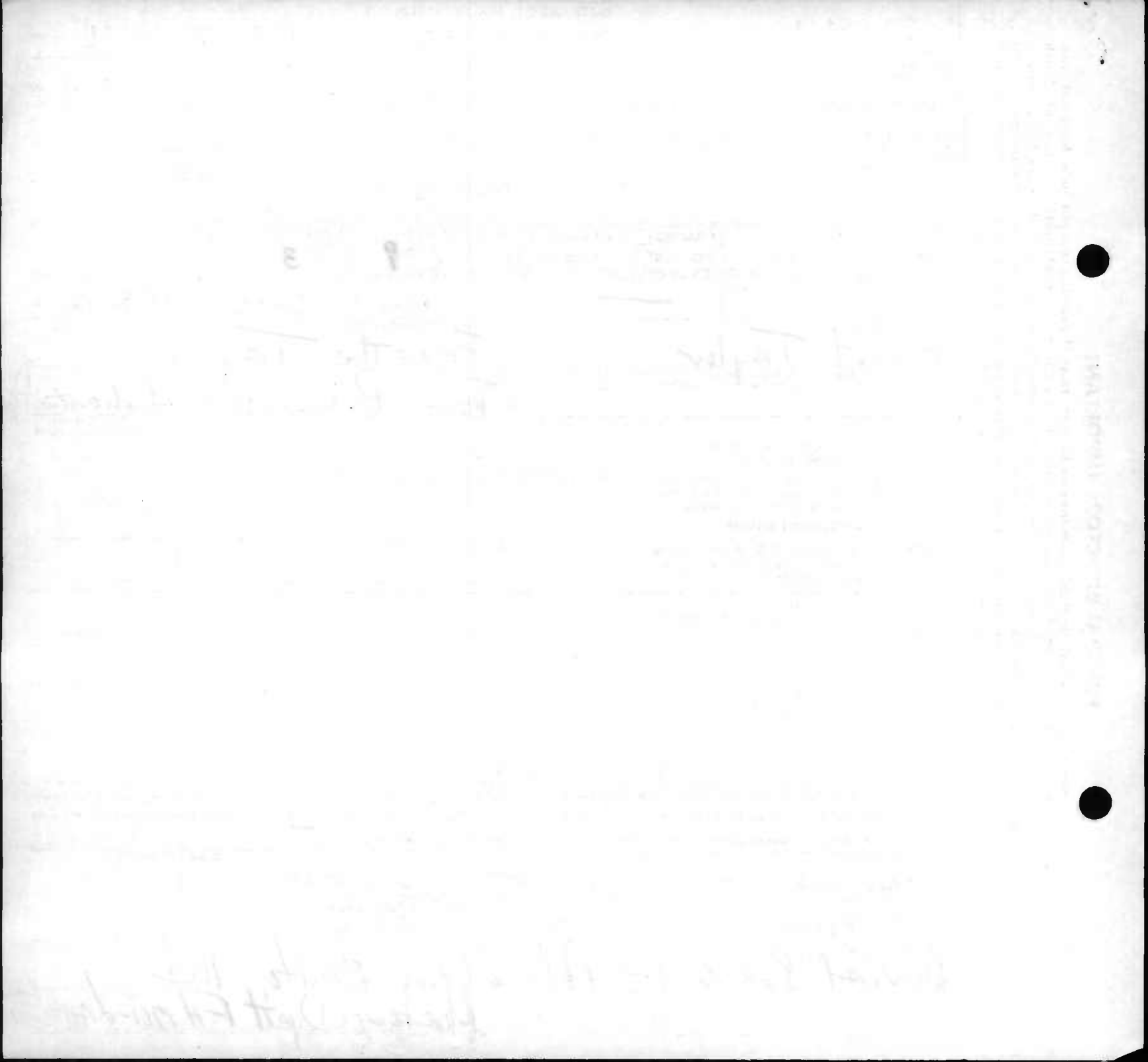
120 ST



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08141	
72 08141					
BIRTH NO. STATE OF MARYLAND - DIMH					
1. NAME OF DECEASED (Type or Print) CARTER LA FRIEDA Taylor			2. DATE AND HOUR OF DEATH August 18, 1972 8:50 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL			C. CITY OR TOWN BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX F			6. RACE BLACK		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5-1-09		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (In years lost birthday) 63		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND, Balto		
12. CITIZEN OF WHAT COUNTRY? U-S-A			13. FATHER'S NAME Robert Taylor		
14. MOTHER'S MAIDEN NAME Jeanette Taylor			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT James Perkins - 6013 - Highgate Dr.		
18. 430.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral aneurysm Aneurysm - Subarachnoid Hemorrhage few days. Stroke Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 8-17-72 to 8-18-72 that (I) (we) last saw the deceased alive on 8-18-72 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ma. Elena V. Mangay MD DEGREE			23B. DATE SIGNED 8/18/72		
23C. PHYSICIAN'S NAME (Type) MA. ELENA V MANGAY MD DEGREE			23D. ADDRESS Provident Hospital 2600 Liberty Heights, Balto. Md		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 8-24-72		
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem			24D. LOCATION (City, town, or county) (State) Balto Md		
25A. DATE REC'D BY HEALTH DEPT. AUG 25 1972			25B. NAME OF REGISTRAR Audrey Winton		
25C. FUNERAL DIRECTOR Mortimer Dyett			25D. ADDRESS F-H 1701 - Laurens St		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO. 72 08142

BIRTH NO. 72-08142

1. NAME OF DECEASED (Type or Print) Loured Sisco

2. DATE AND HOUR OF DEATH 8-24-72 12 30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 1607

C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 1231 Poplar Grove

5. SEX Male 6. RACE Negro 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 5-6-99 9. AGE (In years last birthday) 73 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10B. KIND OF BUSINESS OR INDUSTRY Md Drydock 11. BIRTHPLACE (State or foreign country) Calvert Co Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Phillip Sisco 14. MOTHER'S MAIDEN NAME Hlice Sisco

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 212-4-0292 17. INFORMANT Catherine Johnson ADDRESS 1231 Poplar

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last

(A) IMMEDIATE CAUSE CEREBRAL ANGIOA HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF:

(B) CHRONIC (R) ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: Pneumococcal

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SIX WEEKS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 8-6-72 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CHRONIC EMPHYSEMA 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

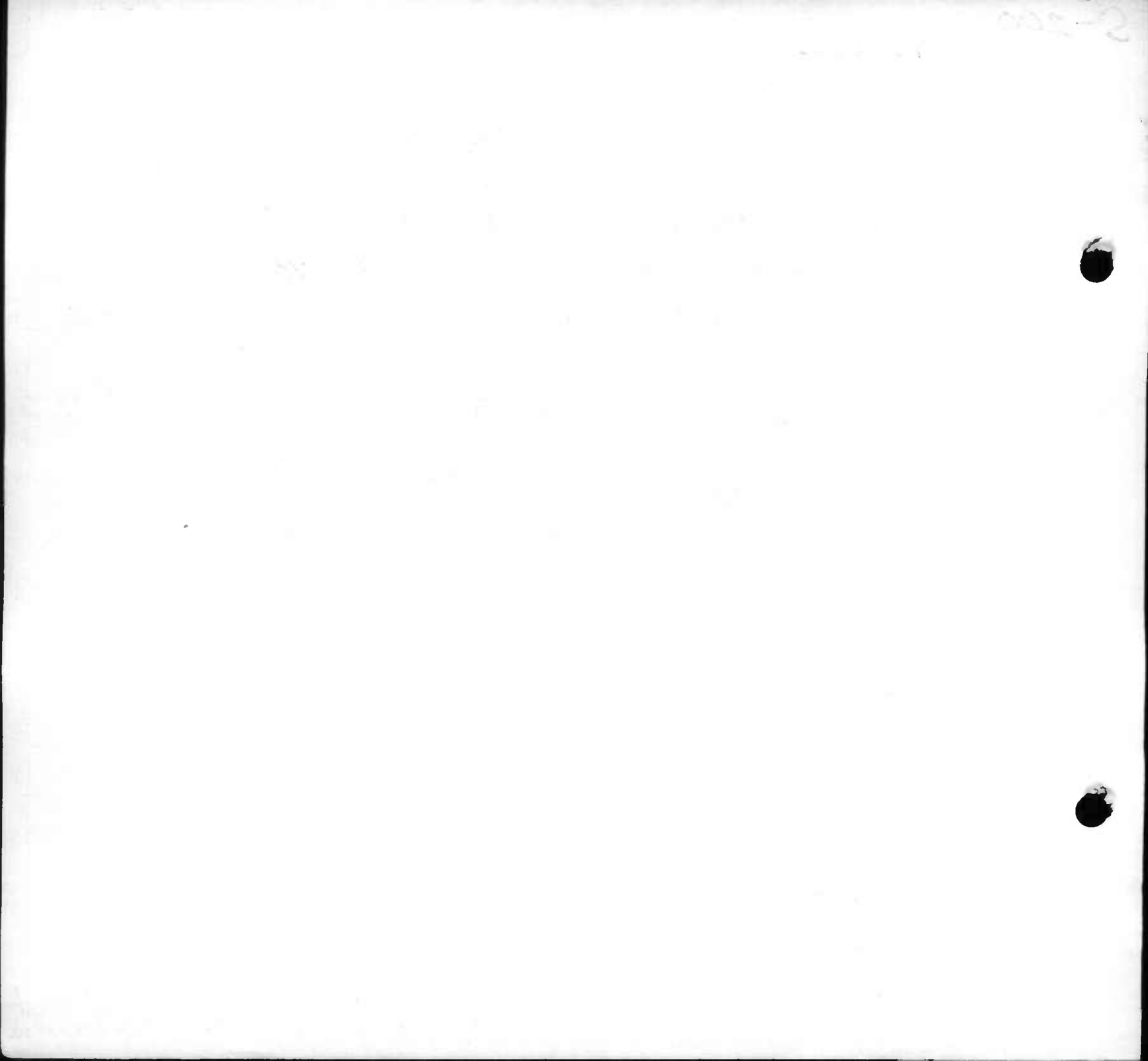
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Famuyina A. Olufunso M.D. DEGREE MD 23B. DATE SIGNED 8-24-72

23C. PHYSICIAN'S NAME (Type) Famuyina A. Olufunso DEGREE MD 23D. ADDRESS Lutheran Hospital 730 Ashblinton St. Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 8-28-72 24C. NAME of CEMETERY or CREMATORY Arbutus Mem Pk 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

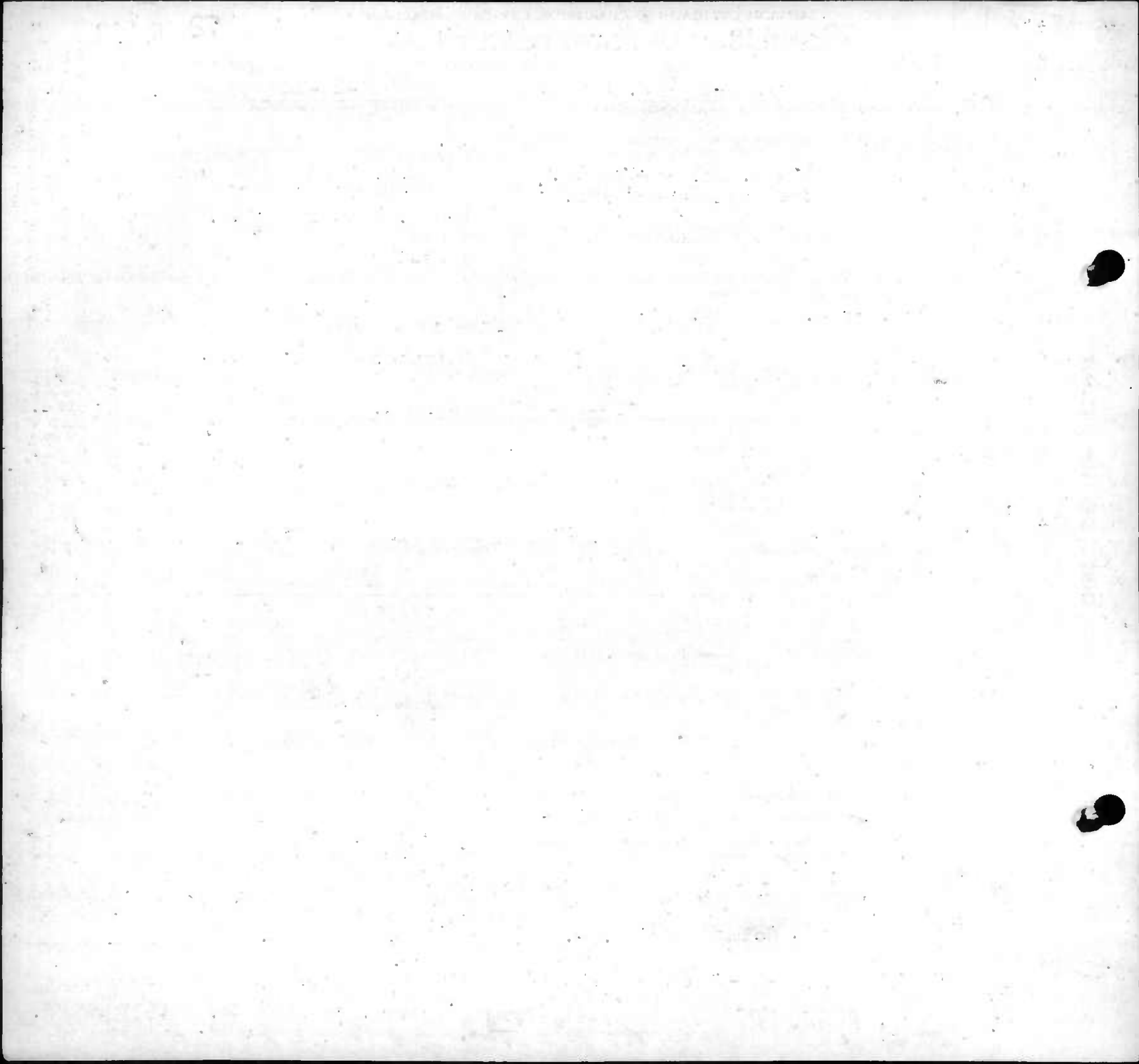
25A. DATE REC'D BY HEALTH DEPT. AUG 25 1972 25B. NAME OF REGISTRAR Friday Winston 25C. FUNERAL DIRECTOR Maxton Dyett ADDRESS 1701-1705





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 08143				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 08143	
1. NAME OF DECEASED (Type or Print) <b>Norbert J. Baumer</b>				2. DATE AND HOUR OF DEATH <b>8-24-72 1:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>100 W. Coldspring La. Wynnwood Towers Apt. 805</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2711</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>100 W. Coldspring La.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-3-78</b>		9. AGE (In years last birthday) <b>93</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Pres.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>A. Gross Candle Co.</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George Baumer</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McDonald</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>213-01-4928A</b>		17. INFORMANT <b>John R. Bibby</b>	
				ADDRESS <b>21212 Montrose Ave.</b>			
18. <b>404X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardio-renal disease</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>renal disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Prostatic hypertrophy</b> DUE TO, OR AS A CONSEQUENCE OF: <b>2 yrs</b>			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May 22 1972</b> to <b>August 24 1972</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>August 23 1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>C. Holmes Boyd M. D.</b>						23B. DATE SIGNED <b>AUG 24 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. Holmes Boyd M. D.</b>						23D. ADDRESS <b>11 E. Chase St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-26-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Hanover, New Jersey</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Johnston</b>		25C. FUNERAL DIRECTOR <b>Henry W. Jenkins Co.</b>		ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

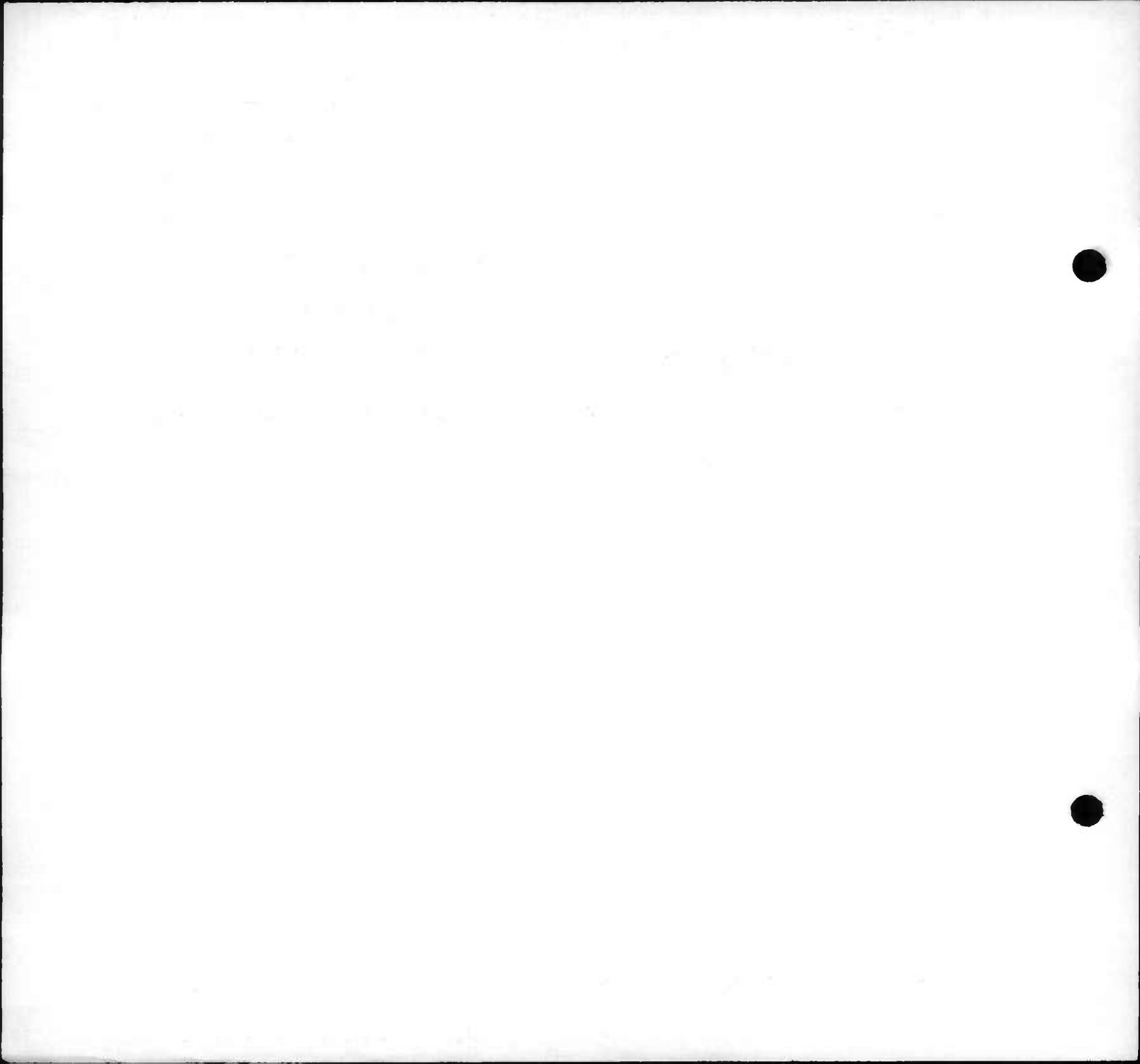
REG. NO. 72 08144

BIRTH NO. 72 08144		STATE OF MARYLAND - DEPT. HEALTH	
1. NAME OF DECEASED (Type or Print) <b>RACHEL TAYLOR HOWARD</b>		2. DATE AND HOUR OF DEATH <b>8/23/72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>712 N. GAY ST</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1002</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>712 N. GAY ST.</b>	
5. SEX <b>F.</b>	6. RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/1900</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>72</b>
13. FATHER'S NAME <b>DANIEL HOWARD</b>		14. MOTHER'S MAIDEN NAME <b>Larena Hardy</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>HANNAH LINDSEY 506 CARGILL AVE</b>
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Disease</b>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Name</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19 6/17 to Aug 19 19 72</b> , that (I) (we) last saw the deceased alive on <b>Aug 19 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Daniel C. Saper MD</b>		23B. DATE SIGNED <b>8/25/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DANIEL C. SAPIR MD</b>		23D. ADDRESS <b>JOHNS HOPKINS</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/28/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Petersville, MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Joseph J. ...</b>	
25C. FUNERAL DIRECTOR <b>Joseph J. ...</b>		ADDRESS <b>1304 N. ...</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-523 72 08145		BALTIMORE CITY HEALTH DEPARTMENT		72 08145	
BIRTH NO.		REG. NO.		STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <b>ESTHER E. JOHNSTON</b>		2. DATE AND HOUR OF DEATH <b>8/20/72 1:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND BALTIMORE</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BENT MARYLAND</b> B. COUNTY <b>1605</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1002 N. BENTALOU STREET</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-16-01</b>	9. AGE in years (lost birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>GEORGE H. EVANS</b>		14. MOTHER'S MAIDEN NAME <b>EMMALINE HAMMOND</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-01-8841A</b>		17. INFORMANT ADDRESS <b>FREDERICK JOHNSTON 1002 BENTALOU ST</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>154.11</b> <b>Carburetor accident</b> <b>6 days</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carburetor accident</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Carcinoma Rectum</b> DUE TO, OR AS A CONSEQUENCE OF: <b>over 2 1/2 months</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>8-4-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma Rectum</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>7-28-1972</b> to <b>8-20-1972</b> that (I) (we) last saw the deceased alive on <b>8-20-1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. M. A. ANWAR</b>		23B. DATE SIGNED <b>8-20-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. M. A. ANWAR</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT AUBURN CEMETERY</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		24E. CITY, town, or county <b>BALTIMORE, MARYLAND</b>		24F. STATE <b>MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>—</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Anlington S. Phillips-1721 N. Monroe St-21217</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08146		REG. NO. 72 08146	
B-326				72 08146		STATE OF MARYLAND-DEHM	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Mr. William Butcher</b>				2. DATE AND HOUR OF DEATH <b>Aug 23, 1972 2:15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1307</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>91</b> <b>Keswick Home of Baltimore City</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-13-81</b>	9. AGE (in years last birthday) <b>91</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Coca Cola Co.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mr. John Butcher</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Butcher ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-5735</b>		17. INFORMANT <b>Dr. R.M. Smith</b>		ADDRESS <b>Severna Park</b>	
18. <b>43691</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CVA with reg of hemiparesis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Traumatic Amputation left leg</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b> <b>7 yrs.</b> <b>28 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4 April 1966</b> to <b>23 Aug 1972</b> that (I) (we) last saw the deceased alive on <b>23 Aug 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Aubrey D. Richardson</b>				23B. DATE SIGNED <b>23 Aug 1972</b>			
23C. PHYSICIAN'S NAME (Type) <b>Aubrey D. Richardson, M.D.</b>				23D. ADDRESS <b>700 W. 40th Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/25/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Raymond C. Fink</b>		25C. FUNERAL DIRECTOR <b>Raymond C. Fink</b>		ADDRESS <b>Glen Burnie, Md.</b>	



700 No 4126

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08147

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Catherine Zeihm</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 22 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>39 Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 22 72 11:56 a.</b> M.	
6. SEX <b>female</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b>	
9. DATE OF BIRTH <b>JAN 19 - 1887</b>		10. AGE (In years lost birthday) <b>79 85</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FERDINAND ZIEHN</b>		14. MOTHER'S MAIDEN NAME <b>BERTHA WALTERS</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		16. KIND OF BUSINESS OR INDUSTRY <b>SEAMSTRESS</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO. <b>218-05-6925</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic cardiovascular disease</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. INFORMATION <b>MARGARET MATTHEW 1145 ADDRESS 21227</b>	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/23/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>AUG 25 - 72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>ST PAUL'S LUTHERAN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>ABERDEEN MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Houston</b>	
25C. FUNERAL DIRECTOR <b>KRAUSE FUNERAL HOME</b>		25D. ADDRESS <b>1216 S. CHARLES ST 21230</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500		72 08148		BALTIMORE CITY HEALTH DEPARTMENT		72 08148	
BIRTH NO.		72 08148		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) BOEHNE, MERLE E				2. DATE AND HOUR OF DEATH AUGUST 21, 1972 6:55A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 100 DORCHESTER RD 21207			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/16/03	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TYPIST		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TYPIST			10B. KIND OF BUSINESS OR INDUSTRY INSURANCE CO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FREDERICK STEINACKER				14. MOTHER'S MAIDEN NAME EMMA WADE STEINACKER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) NONE			16. SOCIAL SECURITY NO. 216-32-3593		17. INFORMANT ST. AGNES HOSPITAL RECORDS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.44250.9 I A my Stole ASCVD DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45'			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NONE		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 18 1972 to AUGUST 21 1972, that (I) (we) last saw the deceased alive on AUGUST 21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE JOSE APTER, M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) JOSE APTER, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-24-72		24C. NAME OF CEMETERY or CREMATORY Lambert Park Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT AUG 25 1972		25B. NAME OF REGISTRAR Lillian H. Hester		25C. FUNERAL DIRECTOR Ferdinand H. Hester		25D. ADDRESS Ferdinand H. Hester	

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-150 BIRTH NO.		72-08149		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 72 08149		STATE OF MARYLAND - DISTRICT	
1. NAME OF DECEASED (Type or Print) NEVIN, PAULINE				2. DATE AND HOUR OF DEATH 8/22/72 1:55PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Harford					
5. SEX FEMALE				6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/21/18	
9. AGE (In years (last birthday)) 54				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Spartanburg, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MOSER, LESLIE				14. MOTHER'S MAIDEN NAME HIGHBERGER, NETTIE FERN					
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 210 09 2157		17. INFORMANT K. Scott Nevin, White Hall, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which gave rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Inability to come off Cardio respiratory bypass (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
19A. DATE OF OPERATION 3/8/22				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary artery Disease		20A. AUTOPSY (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) None				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None			
22. I certify that (I) (this hospital) attended the deceased from August 20 1972 to August 22 1972 that (I) (we) last saw the deceased alive on August 22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Michael Zinn				23B. DATE SIGNED 9/22		23C. PHYSICIAN'S NAME (Type) Michael Zinn			
23D. ADDRESS John Hopkins Hospital				23E. DATE Aug. 23, 1972					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation				24B. DATE Aug. 23, 1972		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 25 1972				25B. NAME OF REGISTRAR John H. Harkins		25C. FUNERAL DIRECTOR John H. Harkins, Delta, Penna.			

5-1-12

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72 08150

BALTIMORE CITY HEALTH DEPARTMENT

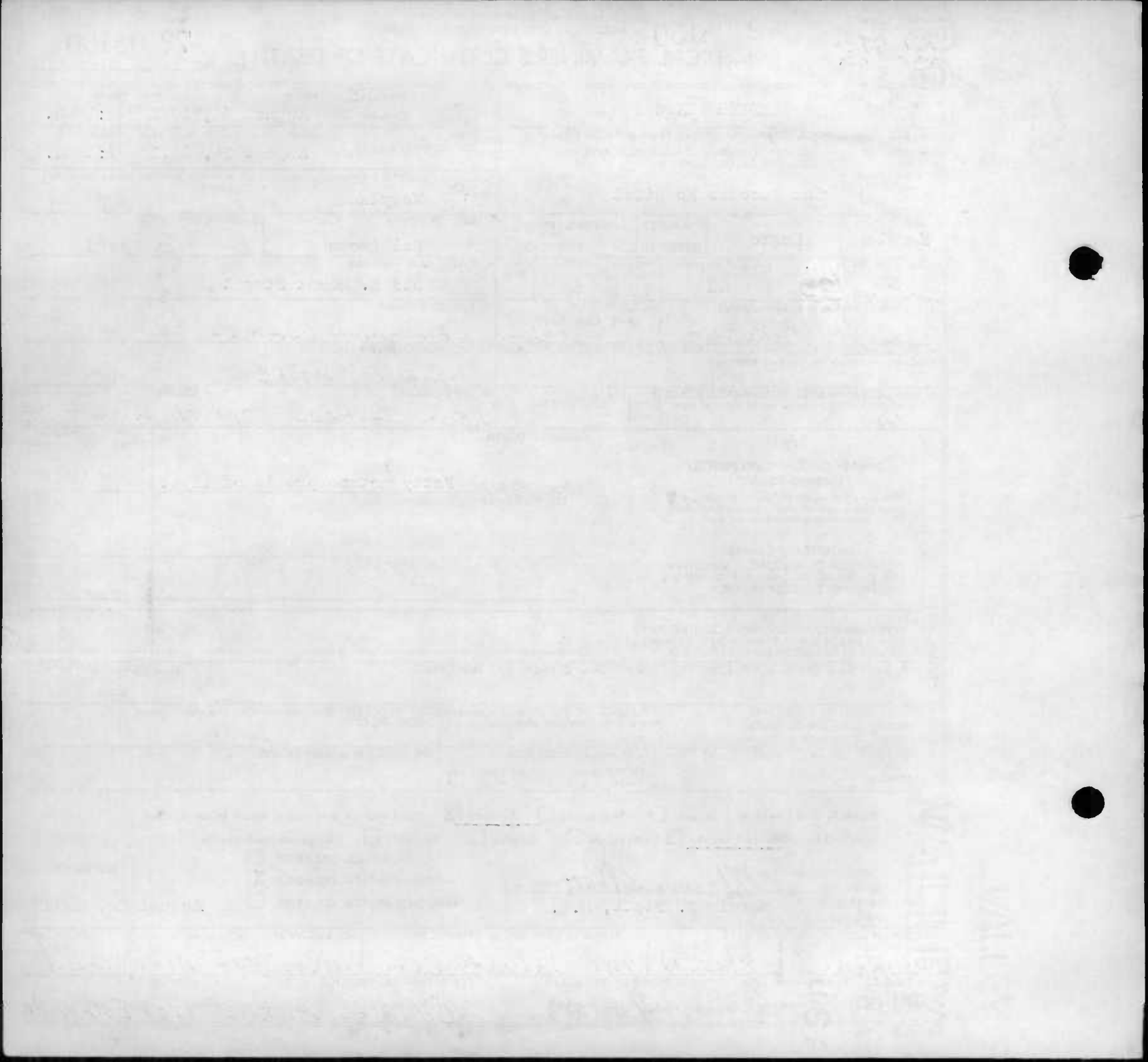
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08150

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>HESTER GATERS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 24, 1972</b>		Hour <b>7:10 A.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 24, 1972</b>		Hour <b>7:10 A.</b>
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>3/12/30</b>		10. AGE (In years lost birthday) <b>42</b>	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>BENJAMIN JAMES</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME <b>JANIE MAC</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.
18. INFORMANT <b>LEON GATERS</b>		19. CAUSE OF DEATH <b>57181</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. DATE OF OPERATION <b>0</b>
21. AUTOPSY? (Yes or No) <b>Yes</b>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR?
27. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
28. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		30. DATE SIGNED <b>August 24, 1972</b>
31. 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		32. 24B. DATE <b>8/28/72</b>		33. 24C. NAME of CEMETERY or CREMATORY <b>mt. CALVARY Cem.</b>
34. 24D. LOCATION (City, town, or county) (State) <b>BROOKLYN, MARYLAND</b>		35. 25A. DATE REC'D BY HEALTH DEPT. <b>AUG 25 1972</b>		36. 25B. NAME OF REGISTRAR <b>Dorothy Johnston</b>
37. 25C. FUNERAL DIRECTOR <b>CHARLES A. RICE</b>		38. 25D. ADDRESS <b>1300 EUTAW PL.</b>		



A-620

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08151

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

STAN HOPE John W. Ayres

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐Month  
Day  
Year8  
25  
72Hour  
8:10A.

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

3. DATE  
PRONOUNCED DEADMonth  
Day  
Year8  
25  
72Hour  
8:10 A.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1803

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9/19/12

10. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

128 S. Arlington Avenue

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Stanley Oscar Ayres

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Shipyard

15. MOTHER'S MAIDEN NAME

Lucie Ayres

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WWII

17. SOCIAL  
SECURITY NO.

18. INFORMANT

Mrs. F. L. Ayres 128 S. Arlington

ADDRESS

BALTO  
MD.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

William P. Mulloy, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-25-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

AUG 28 1972

Sidney H. Hooton

J. L. Schwartz, Inc.

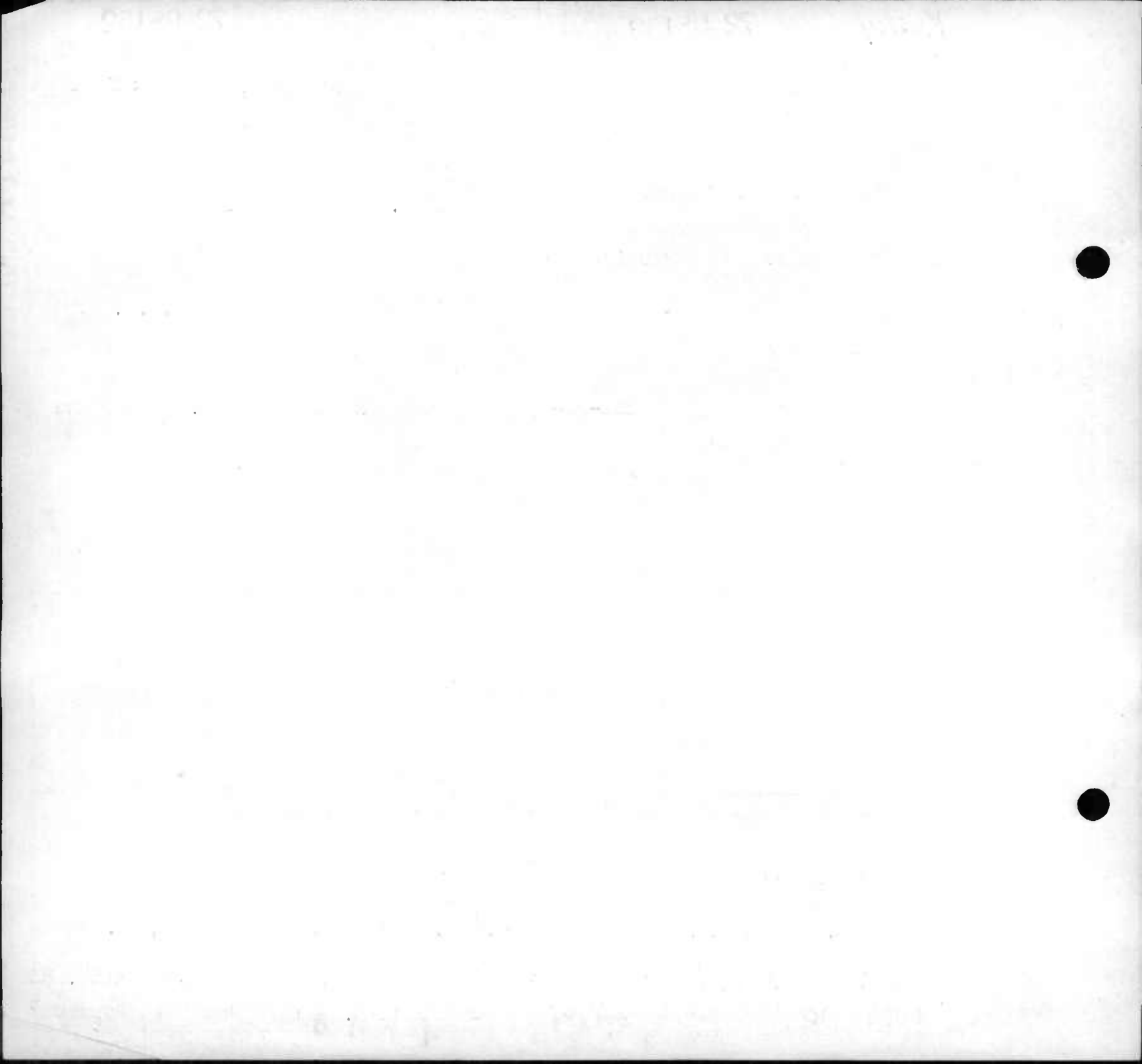
2101 Medfield Ave  
Balt. Md.



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08152	
CERTIFICATE OF DEATH				Registered No. 72 08152	
STATE OF MARYLAND-DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Rose Kragl		August 22nd, 1972   2:27 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
Johns Hopkins Hospital		B. COUNTY 701			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 622 N. Decker Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
Female	White	Married	12/22/88	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife		None	Yugoslavia		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Vosohlo			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		212-01-3727	B Ladislav Kragl 622 N. Decker Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) Atherosclerotic Heart Disease. DUE TO			
		(B) DUE TO			
		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>SEPT 17, 1968</u> to <u>MARCH 17, 1972</u> , that (I) (we) last saw the deceased alive on <u>MARCH 17, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Melito M. Torres, M.D.</i>				23B. DATE SIGNED August 23, 1972	
23C. PHYSICIAN'S NAME (Type) Melito M. Torres, M.D.				23D. ADDRESS M.D. 441 S. Ellwood Avenue, Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/25/72		Bohemian National	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 28 1972		Frederick D. Miller Inc		3019 Monument St	

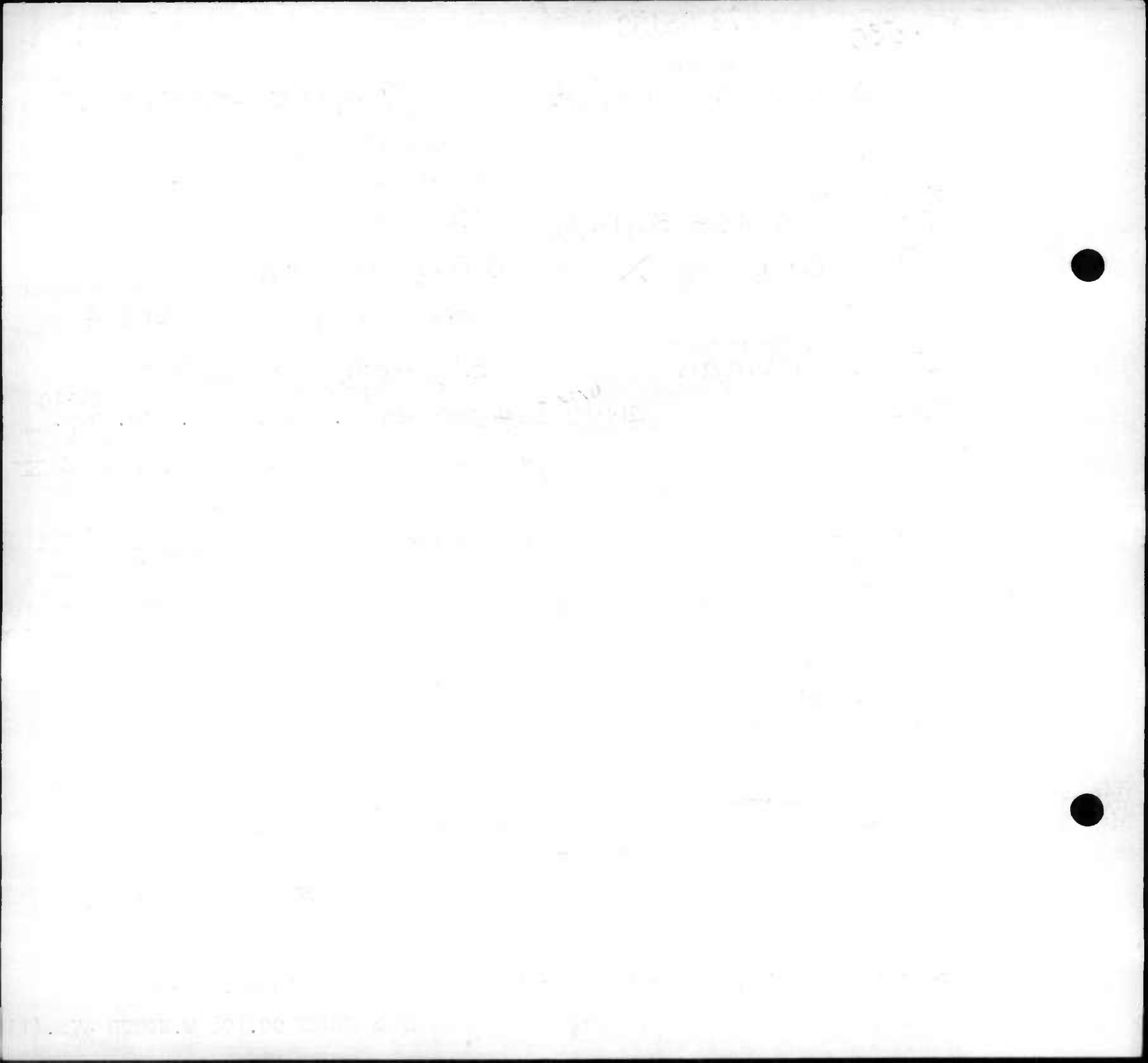


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		72 08153		BALTIMORE CITY HEALTH DEPARTMENT		72 08153	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MARGUERITE Anna M. Schmidt</b>				2. DATE AND HOUR OF DEATH <b>August 24, 1972 - 955 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Keswick</b>				A. STATE <b>Maryland</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>700 W - 40<sup>th</sup> St. Balto., Md.</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>				6. RACE <b>Can</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>OCT. 29, 1878</b>				9. AGE (In years last birthday) <b>93</b>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>JOHN HOHMAN John Hobman</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Schroeder</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>218-52-2284</b>				17. INFORMANT <b>Daughter Katherine S. Korff, 116 W. Univ. Pkwy. 21210</b>			
18. CAUSE OF DEATH <b>410.91</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Anterior dysrhythmia cardiac vascular disease</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>15 yrs -</b>			
(C) _____				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>July 3 1972</b> to <b>August 24 1972</b> and that (I) (we) last saw the deceased alive on <b>August 24 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. Allan Lurie</b>				23B. DATE SIGNED <b>8/24/72</b>		23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>	
23D. ADDRESS <b>DEGREE</b>				23E. ADDRESS <b>DEGREE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/28/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Adrian Houston</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. NORTH AVE. (1)</b>			

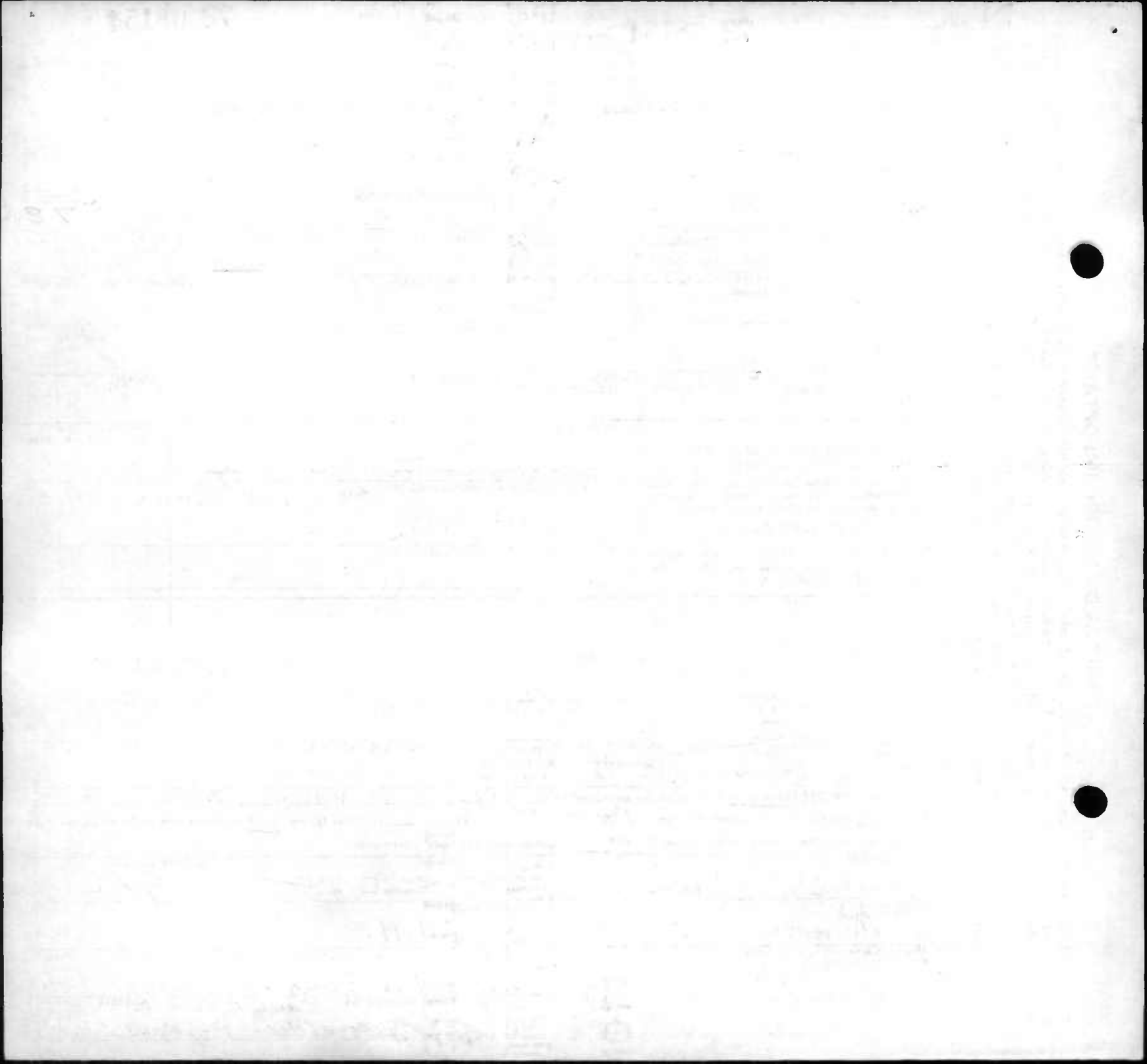




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

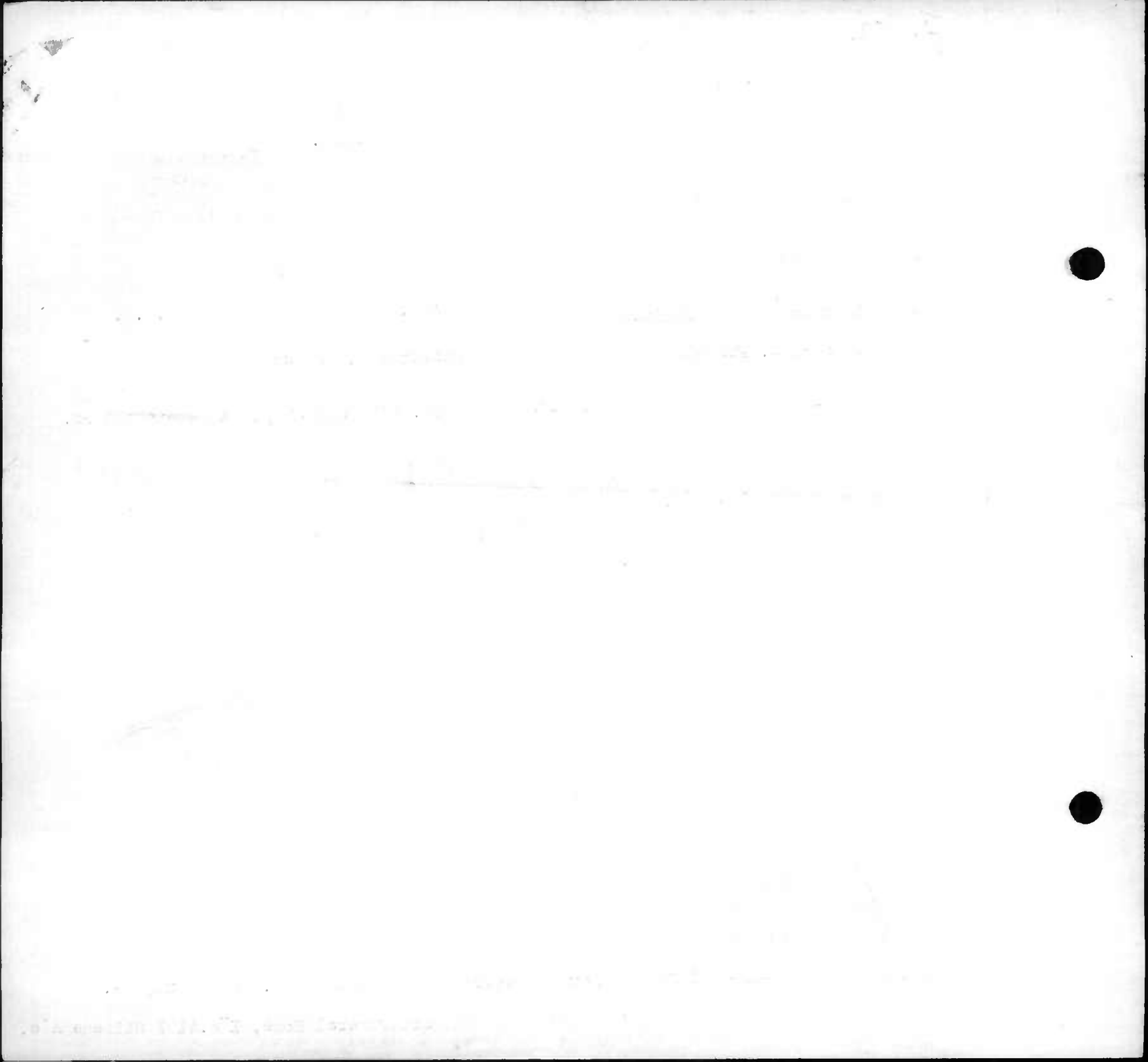
B-500 72 08154		BALTIMORE CITY HEALTH DEPARTMENT		72 08154	
BIRTH NO. <i>Calvert Co. Md.</i>		CERTIFICATE OF DEATH		REG. NO. <i>72 08154</i>	
1. NAME OF DECEASED (Type or Print) <i>ANITA C. BOWEN</i>		2. DATE AND HOUR OF DEATH <i>22 AUGUST 1972, 4:33 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Calvert</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>JOHNS HOPKINS HOSPITAL</i> <i>33 CMSC-ICU</i> <i>601 N. BROADWAY, BALTIMORE, MD. 21205</i>		C. CITY OR TOWN <i>PRINCE FREDERICK</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>CAUCASIAN</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JAN 24, 1972</i>		9. AGE (In years last birthday) <i>6</i> Months <i>29</i> Days <i>29</i> Hours <i>29</i> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>INFANT</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>CALVERT COUNTY HOSP, MD.</i>	
13. FATHER'S NAME <i>ALLEN H. BOWEN, Jr.</i>		14. MOTHER'S MAIDEN NAME <i>EILEEN F. GOTSIS</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>FATHER</i> ADDRESS <i>PRINCE FREDERICK, MARYLAND</i>	
18. <i>743.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Central CV. collapse</i> DUE TO, OR AS A CONSEQUENCE OF: <i>2nd to CNS damage</i> <i>T90, USD</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Congenital Heart Disease</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>8/21</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>USD, T90</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>8/21</i>		21E. INJURY OCCURRED White <input checked="" type="checkbox"/> Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/21</i> 19 <i>72</i> to <i>8/22</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8/22</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Michael Zinn</i>				23B. DATE SIGNED <i>8/22</i>	
23C. PHYSICIAN'S NAME (Type) <i>Michael Zinn</i>		23D. ADDRESS <i>J.H.H.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/25/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Southern Memorial Gardens</i>	
24D. LOCATION (City, town, or county) (State) <i>DUNKIRK, CALVERT, MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 28 1972</i>			
25B. NAME OF REGISTRAR <i>Sandra H. Wilson</i>		25C. FUNERAL DIRECTOR <i>Beall's Funeral Home, Port Republic, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

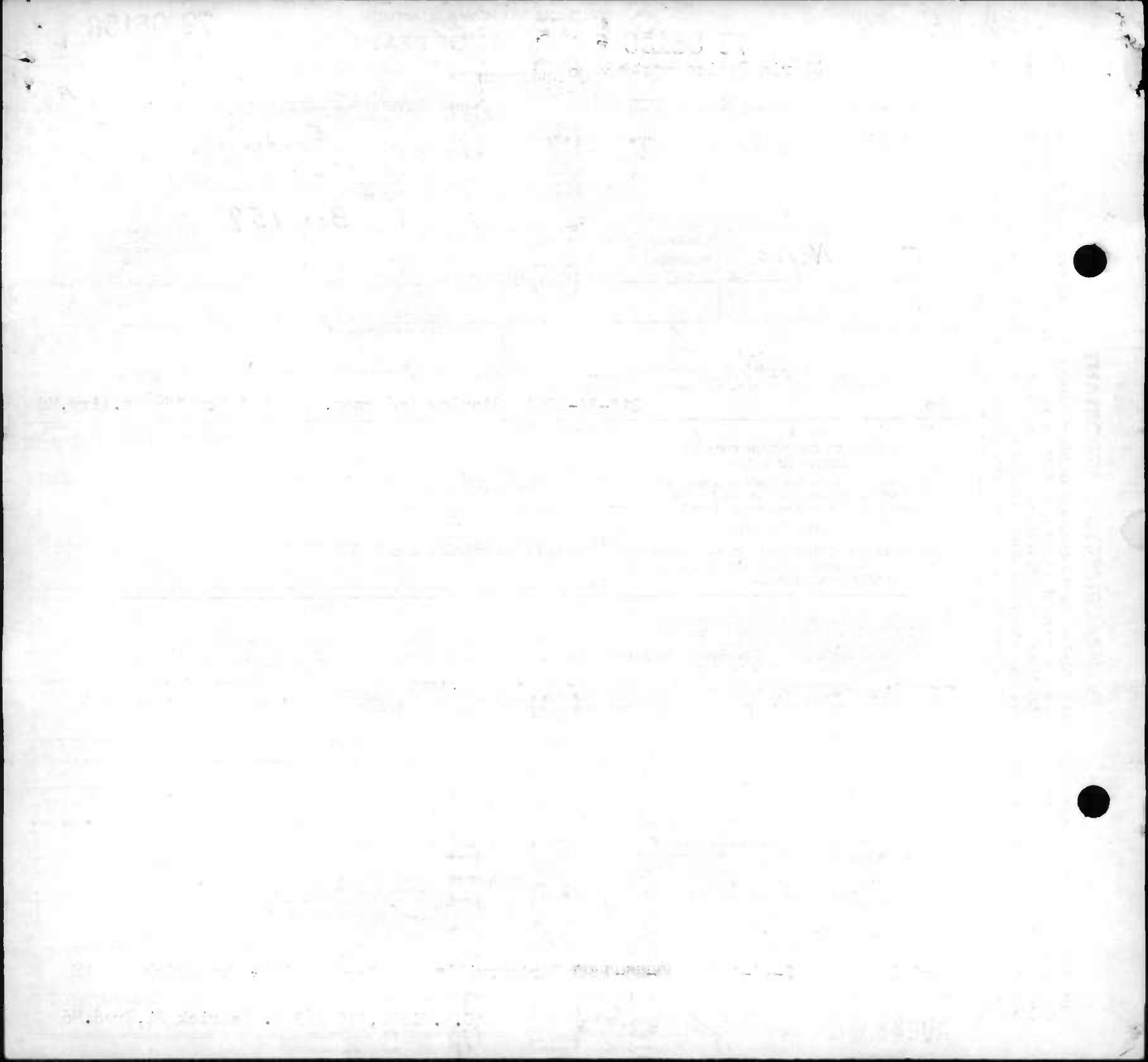
7.652		72 08155		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08155	
<b>CERTIFICATE OF DEATH</b>				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <i>Paul L. Franichin</i>				2. DATE AND HOUR OF DEATH <i>8/21/72 7:30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Scnai Hospital of Baltimore</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <input checked="" type="checkbox"/> Balto. B. COUNTY <i>1538</i>			
				C. CITY OR TOWN <i>City</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3510 Powhatan Avenue</i>			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5/25/1903</i>		9. AGE (In years last birthday) <i>69</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Horticulturist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Mass.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin A. Franklin</i>				14. MOTHER'S MAIDEN NAME <i>Jeanette E. Hazlett</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-16-0683</i>		17. INFORMANT <i>Mrs. Zilpha Platky, 601 Bennington Dr.</i>			
18. <i>41231</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardio-pulmonary Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>At least 1 1/2 months</i>	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolism</i>			
				(C) <i>Athero Sclerotic Heart Disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Sudhindra</i>				23B. DATE SIGNED <i>8/21/72</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>R. SUDHINDRA</i>				23D. ADDRESS <i>Scnai Hosp. of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-26-1972</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Wilkins Ave. Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 28 1972</i>		25B. NAME OF REGISTRAR <i>Henry M. Brown</i>		25C. FUNERAL DIRECTOR <i>Hubbard Funeral Home, Inc. 4107 Wilkins Ave.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-120L		A-536		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08156	
72 08156 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
		Gloria Denise WestSavage Anderson GLORIA SAVAGE		8/22/72 19:05 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		5. CITY OR TOWN	
33		JOHNS HOPKINS HOSPITAL		MARYLAND Frederick 6000		FREDERICK	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6/10/39	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSE WIFE				FREDERICK		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
RAYMOND WEST				ETTA BROWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		215-34-2584		Stanley Anderson, Jr		Rt 1 Box 159 Mt. Airy, Md	
18. 277X I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <i>Pneumonia</i>			
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) <i>Asphyxia</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
II				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/22 19 72 to 8/22 19 72 that (I) (we) lost saw the deceased alive on 8/22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
James H. Mersby MD				8/22/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JAMES H. MERSBY MD				JOHNS HOPKINS HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-25-1972		Bartonsville		Bartonsville Frederick Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 28 1972		Sidney Johnston		C.E. Hicks, 111 263 W. Patrick St, Fred. Md			





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J-632-

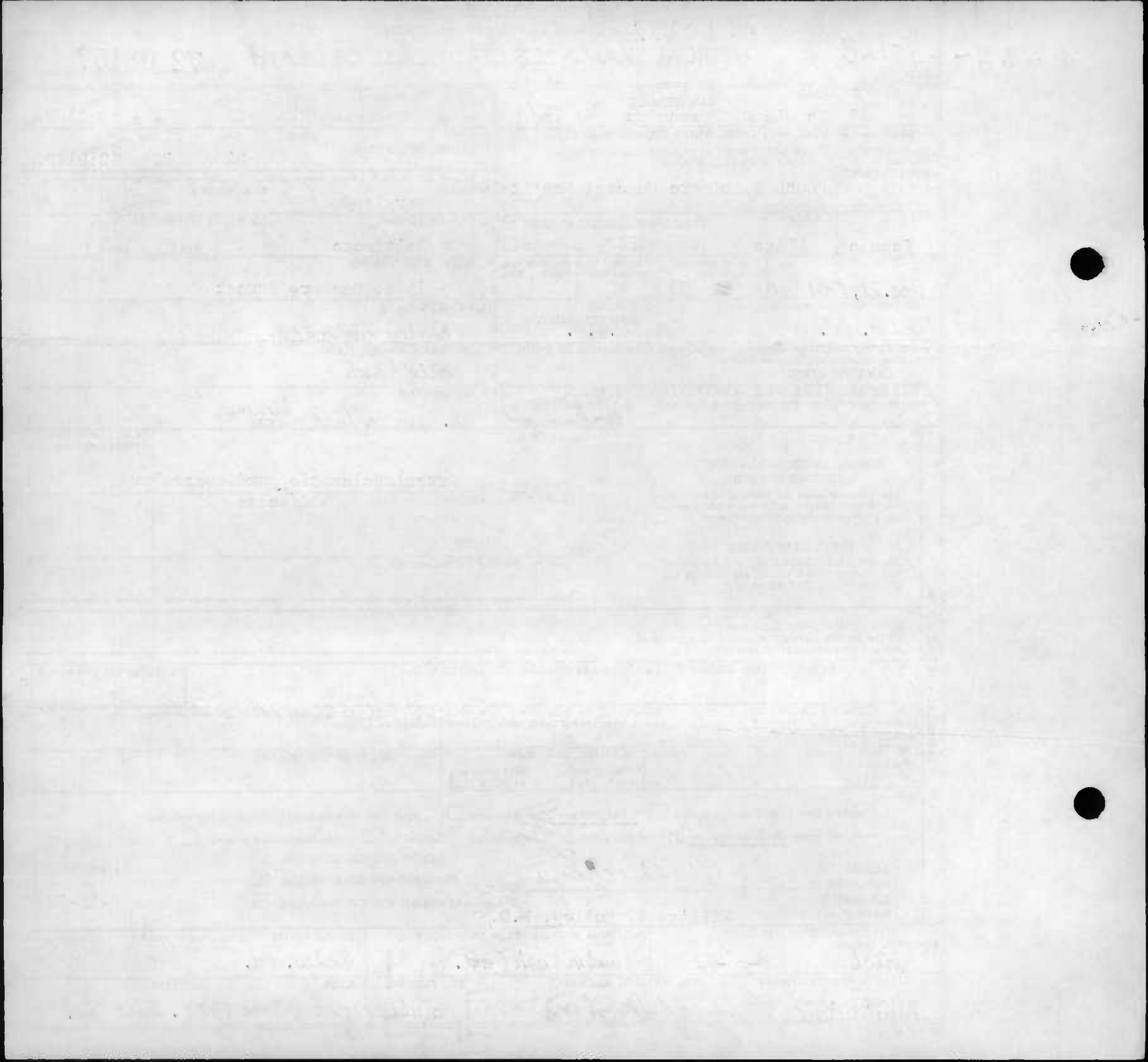
J-623

STATE OF MARYLAND - DEMO  
72 08157 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08157

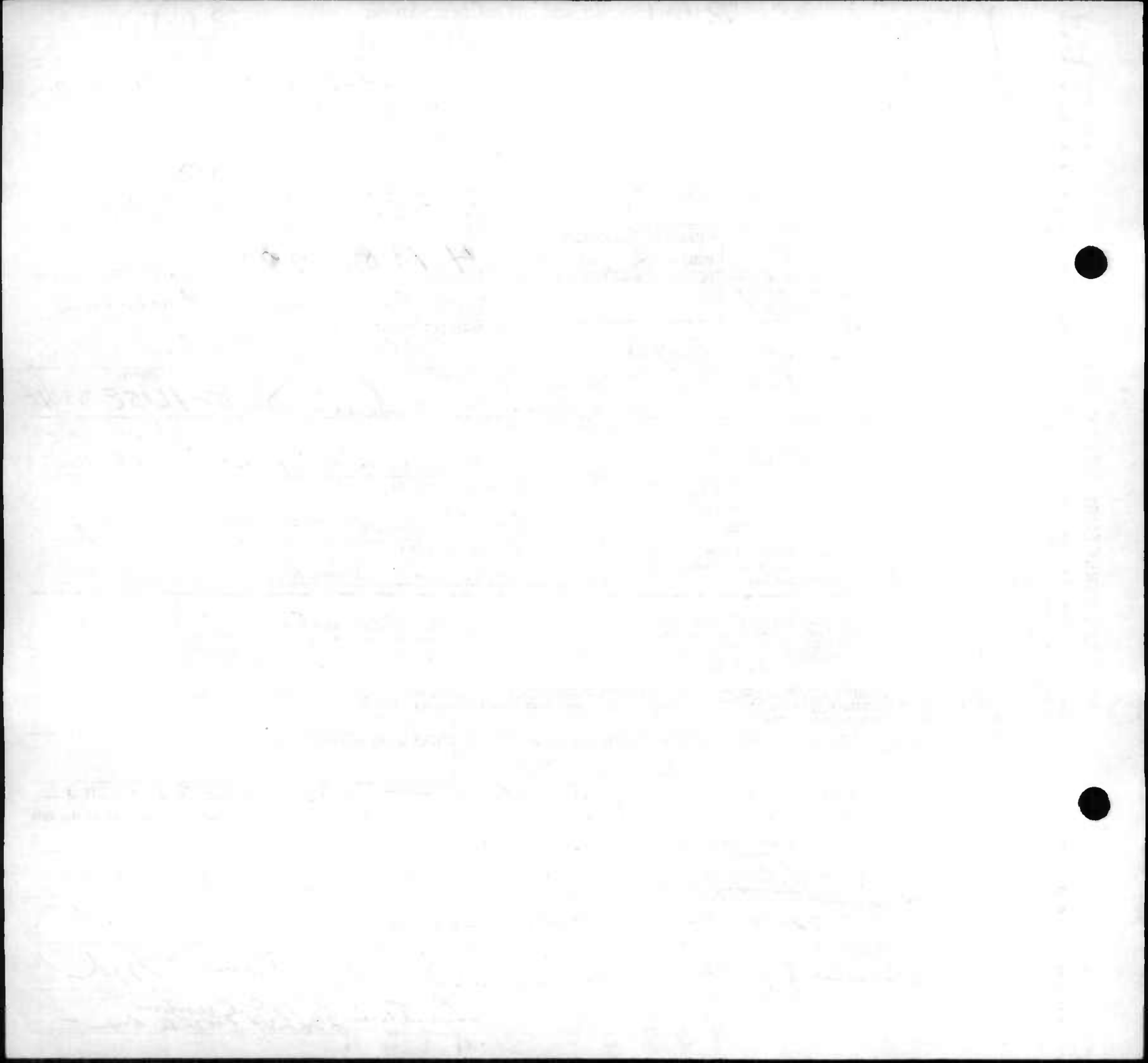
1. NAME OF DECEASED (Type or Print) <i>Jurkavitz</i> <i>Jennie C. Jurrewitz</i>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 24 72 12:01 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 South Baltimore General Hospital</i>		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 24 72 12:01 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH <i>Dec. 21, 1901</i>		10. AGE (In years lost birthday) <i>70</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <i>Katie Wauch</i>		13. FATHER'S NAME <i>Charles Jurkavitz</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		17. SOCIAL SECURITY NO. <i>Unknown</i>	
18. INFORMANT <i>Mrs. Anna Ingart</i>		ADDRESS <i>Clinton Iowa</i>	
19. <i>412.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION <i>0</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-25-72			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-28-72</i>	
24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemt.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 28 1972</i>		25B. NAME OF REGISTRAR <i>Sidney Johnston</i>	
25C. FUNERAL DIRECTOR <i>McGully Funeral Home</i>		ADDRESS <i>130 E. Fort Ave.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

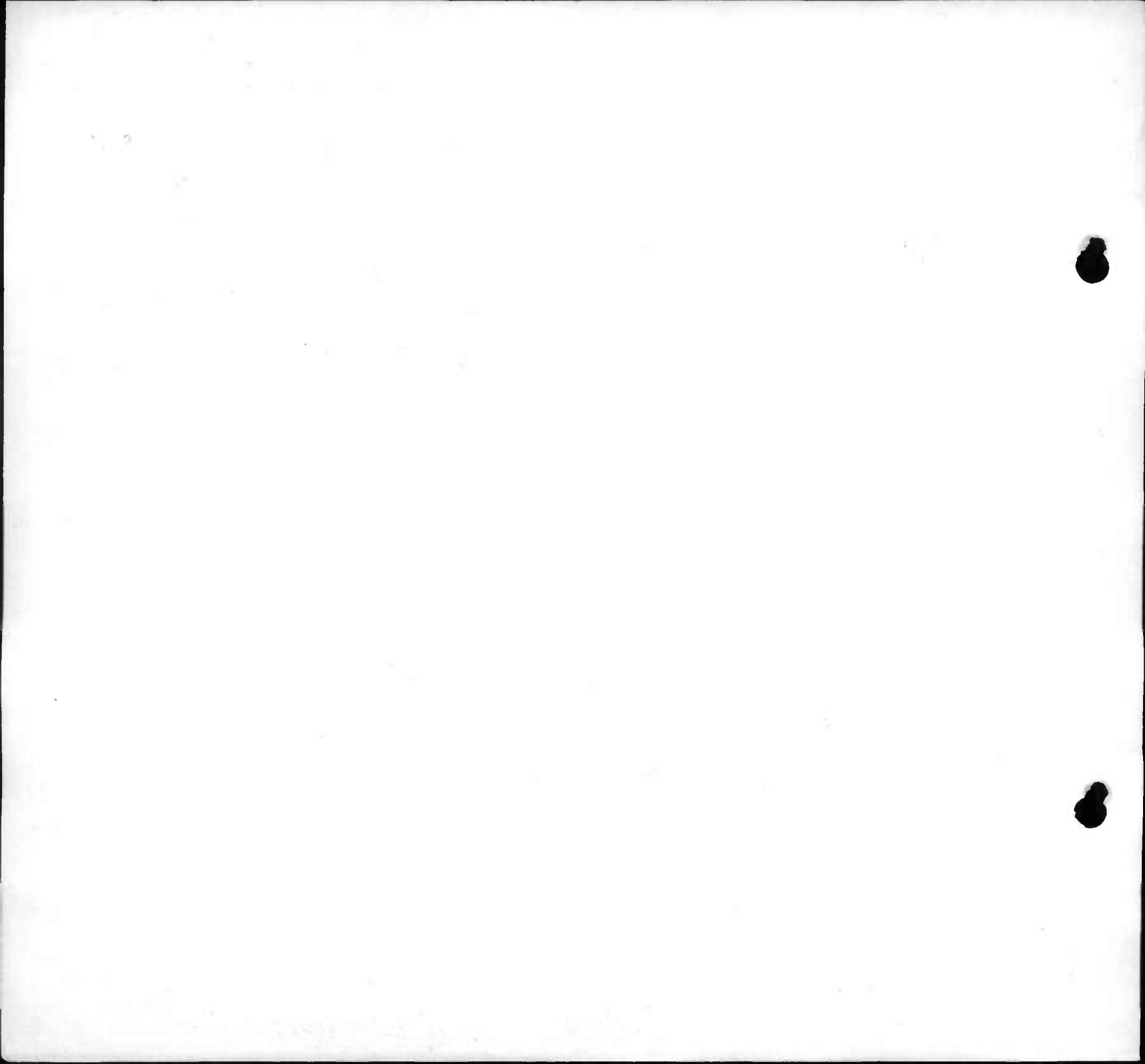
C-600		72 08158		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08158	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EMMA CHERRY</b>				2. DATE AND HOUR OF DEATH <b>08-27-72 01:05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>906</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1615 E. 33rd. Street, Bldg. No.</b>			
5. SEX <b>F.</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-13-02</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>American</b>	
13. FATHER'S NAME <b>John Boyd</b>				14. MOTHER'S MAIDEN NAME <b>Martha Barber</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>MMA-3016757-930</b>		17. INFORMANT <b>Sallie Slater</b>		ADDRESS <b>1615 E 33rd</b>	
18. <b>038.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 Min.</b>	
				(B) <b>Acute renal failure</b>		<b>2 days.</b>	
				(C) <b>Septicemic shock.</b>		<b>1 week</b>	
II				<b>Cerebrovascular Accident.</b>		<b>1 day</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>08-19-1972</b> to <b>08-27-1972</b> that (I) (we) last saw the deceased alive on <b>08-27-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dante Manyari, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>08-27-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DANTE MANYARI, M.D.</b>				23D. ADDRESS <b>The Union Memorial Hospital.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8 31, 72</b>		24C. NAME of CEMETERY or CREMATORY <b>Int. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Andrew Whorton</b>		25C. FUNERAL DIRECTOR <b>Althia Proctor</b>			



# FUNERAL DIRECTOR: IMPORTANT

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C-636		72 08159		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08159	
<b>CERTIFICATE OF DEATH</b>				STATE OF MARYLAND			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		CARTER John S.		8/28/92		2:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
461 Lutheran Hospital				Maryland 1504			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		N		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5-17-17	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John				Mollie Barbara			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) cerebral vascular accident			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0						NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/27/92 19 to 8/28/92 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
E. SANDOZ M.D.							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/31/92		Mt Auburn		Baltimore Md	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 28 1972		Sidney Whorton		Elizabeth M. Hickman			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 70-23123

1. NAME OF DECEASED (Type or Print) PAUL JUNIOR AUSTIN, III		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 26, 1972 Hour 9:12 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour August 26, 1972 9:12 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12/21/70		10. AGE (In years, months, days, hours, minutes) 21	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Paul Austin		15. MOTHER'S MAIDEN NAME Angeline Bradley	
18. INFORMANT Address 3429 East		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebro-cranial injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 8-26-72		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8-26-72 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 725 George St. Apt. 13 J.		22F. HOW DID INJURY OCCUR? Presumably fell out of window-13th flr.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		21. AUTOPSY? (Yes or No) Yes	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 27, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/30/72	
24C. NAME of CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT AUG 28 1972		25B. NAME OF REGISTRAR Sidney Wharton	
25C. FUNERAL DIRECTOR Address 3302 W North Ave Baltimore		25D. ADDRESS	



1847

Dear Sir

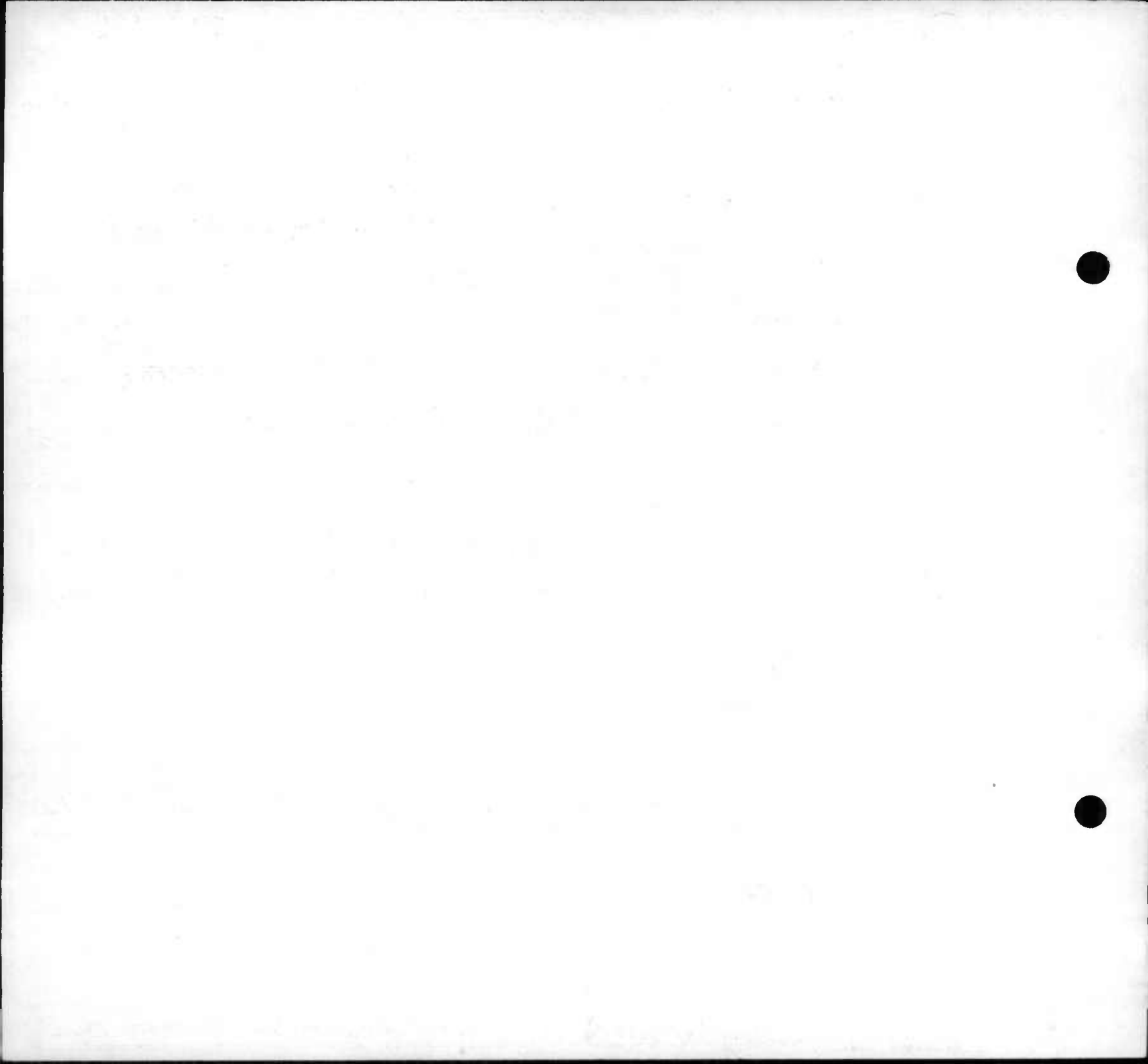
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named subject.

Yours truly

Wm. L. G. 1847

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

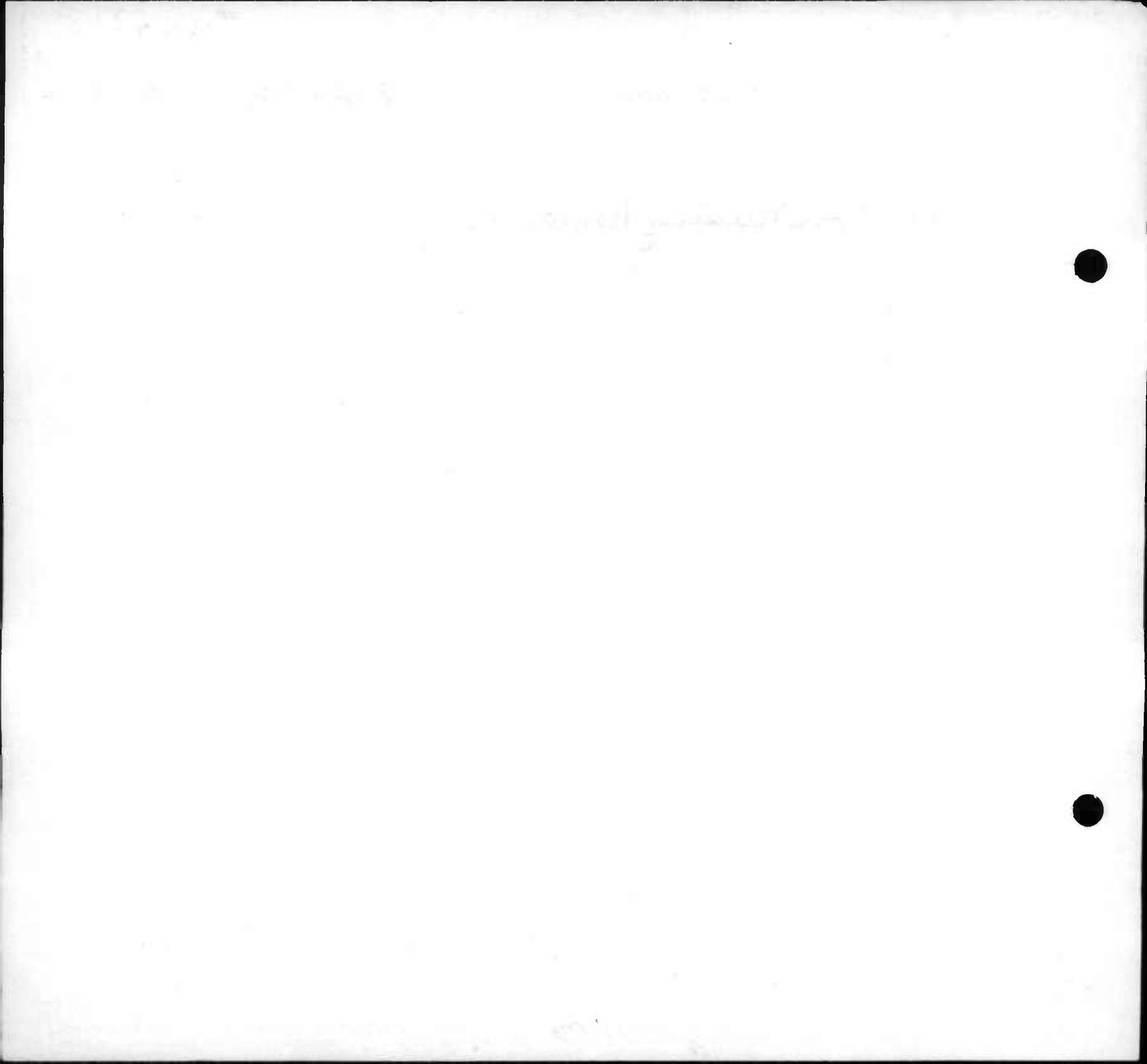
BALTIMORE CITY HEALTH DEPARTMENT				72 08161		REG. NO. 72 08161		STATE OF MARYLAND-DEMI	
BIRTH NO. S-530		72 08161		<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <b>WOODROW SMITH</b>				2. DATE AND HOUR OF DEATH <b>8-25-72 1:45 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>301</b>		C. CITY OR TOWN <b>CITY</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3.6.1917</b>		9. AGE (in years last birthday) <b>55</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>ROGER SMITH</b>				14. MOTHER'S MAIDEN NAME <b>BETTY SKIPWORTH SKIPPARY</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>+</b>		16. SOCIAL SECURITY NO. <b>226-18-8840</b>		17. INFORMANT <b>Hospital chart.</b>					
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
				(B) <b>Acute Anterior MI - Bilateral</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Bundle Branch Block</b>		<b>18 days</b>			
				(C) <b>Coma, probable cerebral ischemia</b>		<b>18 days</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>8-7-72</b> 19 <b>72</b> to <b>8-25</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8-25</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Satpal Singh M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8-25-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>SATPAL SINGH M.D.</b>		23D. ADDRESS <b>Church Home &amp; Hospital.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-29-72</b>		24C. NAME of CEMETERY or CREMATORY <b>MT Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Cty., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Johnston</b>		25C. FUNERAL DIRECTOR <b>WM. C. MARCH</b>					
				ADDRESS <b>928 E North Ave</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

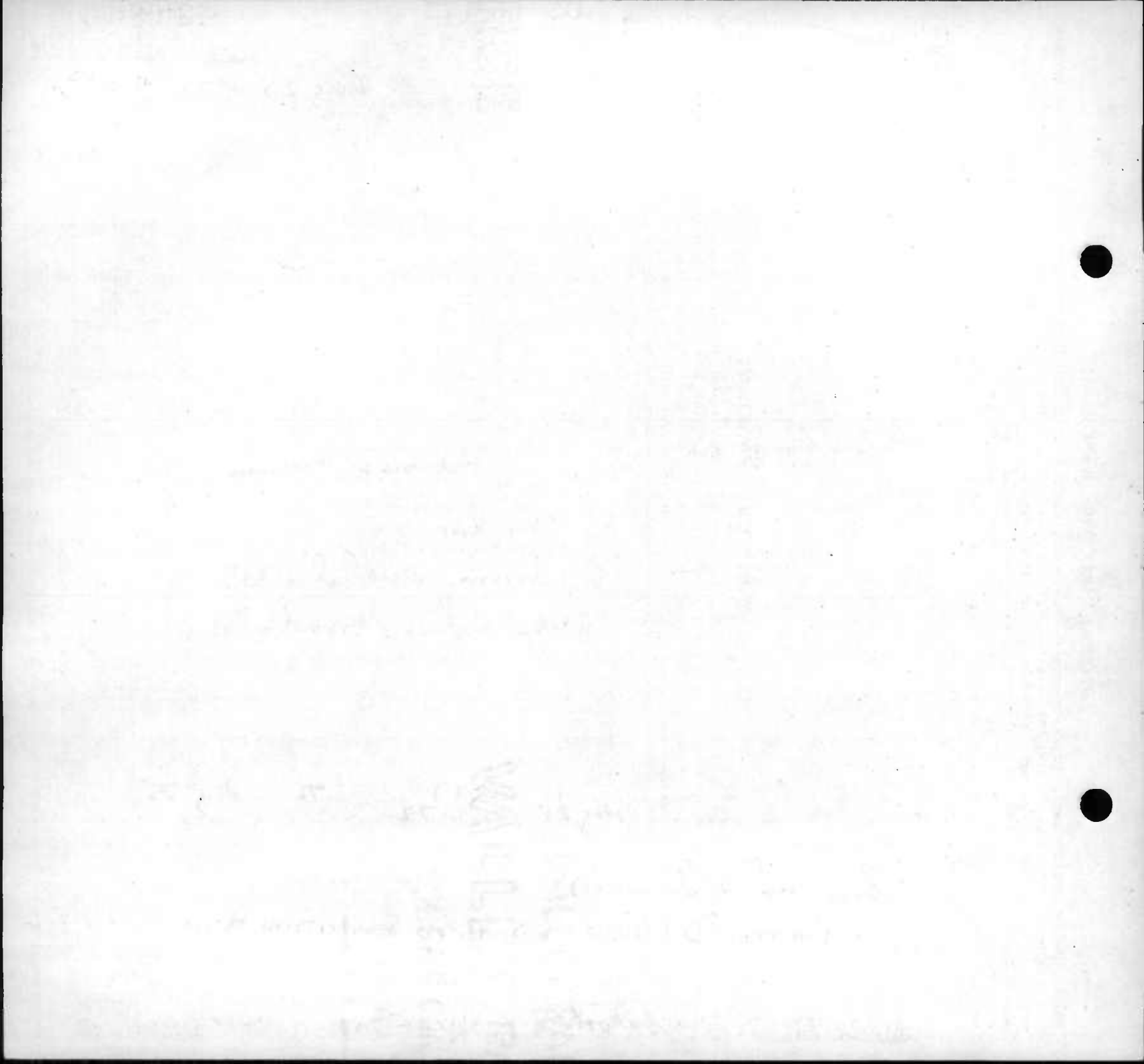
E-562		BALTIMORE CITY HEALTH DEPARTMENT		# 44072 08162
72 08162		CERTIFICATE OF DEATH		REG. NO.
BIRTH NO.		STATE OF MARYLAND-DEME		
1. NAME OF DECEASED (Type or Print) <u>Agnes Emerson</u>		2. DATE AND HOUR OF DEATH <u>8-24-72</u> <u>5:15</u> <u>P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Molechoir Nursing home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1509</u>		
		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2129 Mt. Holly Ave, Md.</u>		
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-86</u>	9. AGE (In years last birthday) <u>85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Samuel Davies</u>		
14. MOTHER'S MAIDEN NAME <u>Sarah Bell 72 08163</u>		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>218-305325A</u>		17. INFORMANT ADDRESS <u>5A. Kathleen Beale 1625 Druid Hill Rd.</u>		
18. <u>41241</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardio-vascular Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5-26-</u> <u>1971</u> to <u>present - 8</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>8-14</u> <u>1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Loy M. Zimmerman M.D.</u>		23B. DATE SIGNED <u>8/25/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman M.D.</u>
23D. ADDRESS <u>3202 Hartford Rd, Baltimore, Md</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>8-26-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>		25B. NAME OF REGISTRAR <u>Lidney Whorton</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm C. MARCH 928 E North Ave</u>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08163</b>
C-152 72 08163				STATE OF MARYLAND-DEATH
BIRTH NO. <b>C-152</b>		1. NAME OF DECEASED (Type or Print) <b>COVINGTON, BETTY J. (JENKINS)</b>		
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <b>Aug 25, 1972 12 05 P. M.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>45 GOOD SAMARITAN HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>906</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>F</b>		6. RACE <b>BLACK</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>12-20-45</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>L.P.N. / HOUSEWIFE</b>		9. AGE (In years last birthday) <b>26</b>		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PA.</b>		
13. FATHER'S NAME <b>DAVID COVINGTON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>ANNA WILSON</b>		
16. SOCIAL SECURITY NO. <b>215422112</b>		17. INFORMANT <b>MRS ANNA CORPORAL 3915 Edmondson</b>		
18. <b>582X I</b>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Probable septicemia</b> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Anephric</b> DUE TO, OR AS A CONSEQUENCE OF:		
		(C) <b>Chronic renal disease</b>		
<b>II</b>		<b>Prolonged abstinence from dialysis</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 17 1972</b> to <b>Aug 25 1972</b> , that (I) (we) last saw the deceased alive on <b>Aug 25 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Timothy D. Carnes</b>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>TIMOTHY D. CARNES MD</b>				23D. ADDRESS <b>GOOD SAMARITAN HOSP BALT. 21212</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-29-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Cemetery</b>
24D. LOCATION (City, town, or county) <b>BALTO, MD.</b>		24E. (State)		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Audrey [Signature]</b>		25C. FUNERAL DIRECTOR <b>WM C STARCH</b>
				ADDRESS <b>928 E. NORTH AVE</b>





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08164

BIRTH NO.

C.

1. NAME OF DECEASED (Type or Print) <b>CRUZ A. VASQUEZ</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 26, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year August 26, 1972		Hour M. 5:00 A.M.	
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5-3-26		10. AGE (In years last birthday) 46		11. BIRTHPLACE (State or foreign country) Puerto Rico	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 316-30-1900	
18. INFORMANT		19. CAUSE OF DEATH		ADDRESS Elizabeth Vasquez 505 N Longwood St.	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) Yes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Basement - 505 N. Longwood Street	
22D. TIME OF INJURY (APPROX.) 8-26-72 3:25 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot self	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 26, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-30-72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR Ludwig Johnson	
25C. FUNERAL DIRECTOR Wm C March 928 E North Ave.		25D. ADDRESS			

12130 ST. ... 24 ...

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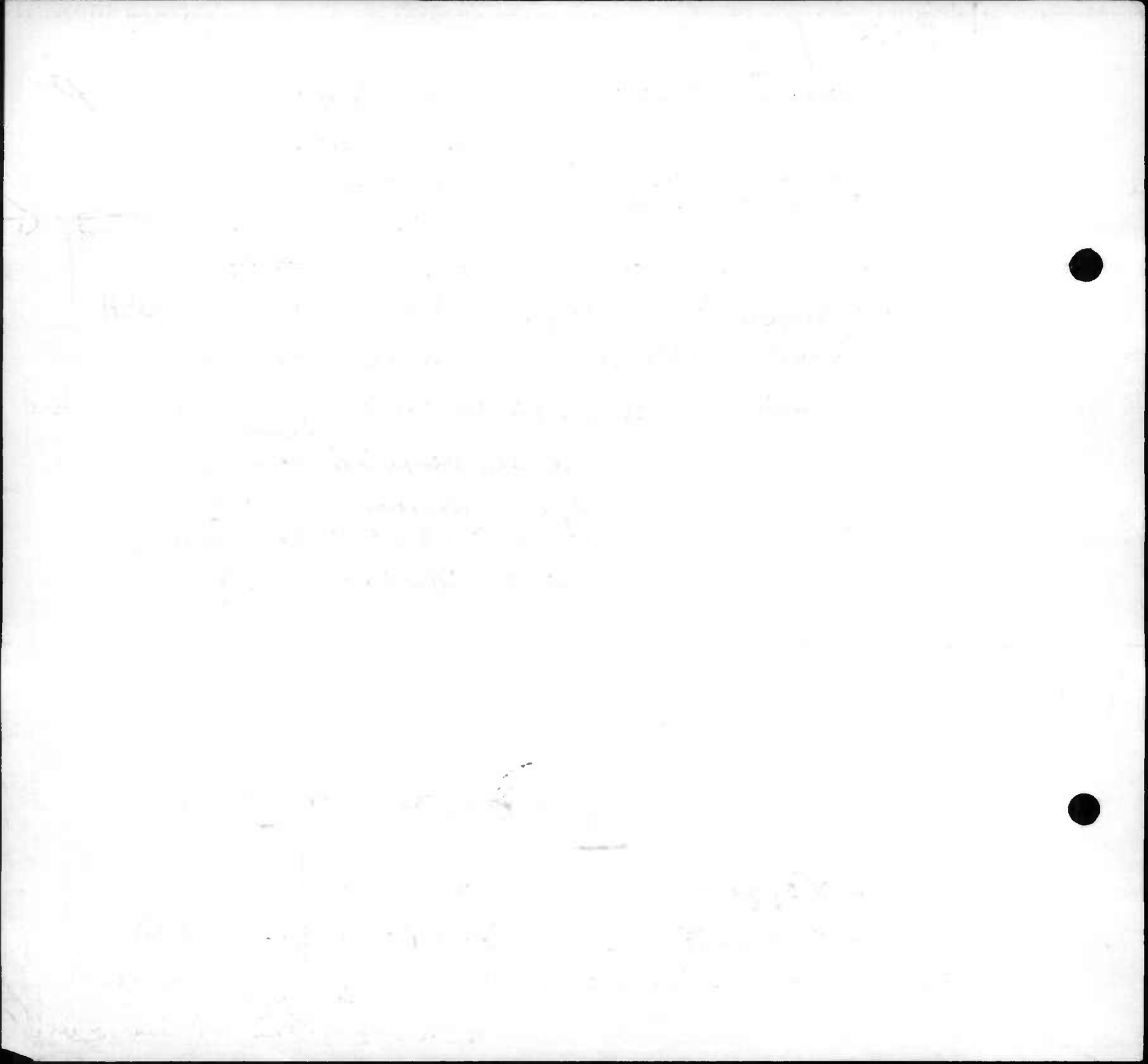
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-523		72 08165		BALTIMORE CITY HEALTH DEPARTMENT		72 08165	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>M. Margaret Bannister</b>				2. DATE AND HOUR OF DEATH <b>Aug 24 1972 1:25 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Century Home, Inc. 102 N. Paca St. 21201</b>				A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b>			
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>3/22/88</b> 9. AGE (in years last birthday) <b>85 84</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Masonic Temple</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Peter Gallion</b>				14. MOTHER'S MAIDEN NAME <b>Kate France</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213036985 A</b>		17. INFORMANT <b>Edith Lang</b> ADDRESS <b>145 N. Ellwood Ave</b>	
18. <b>41241</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio Respiratory Failure</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic CVD</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Genit Cerebral Arteriosclerosis</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Ca of Bladder (?)</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 30 1971</b> to <b>Aug 24 1972</b> that (I) (we) last saw the deceased alive on <b>AUG 24 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <b>Willard Appleford</b> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Willard Appleford</b> DEGREE				23D. ADDRESS <b>6615 Reisterstown Rd</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-26-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Swartz Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE RECD. BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Edith Lang</b>		25C. FUNERAL DIRECTOR <b>Willard Appleford</b>		ADDRESS <b>1211 Chesapeake</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08166		REG. NO. 72 08166	
BIRTH NO. L-250				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LAWSON, CHARLES EDWARD</b>				2. DATE AND HOUR OF DEATH <b>AUGUST 24, 1972 1:55 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL</b> <b>40</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2582</b>			
5. SEX <b>MALE</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH <b>11-04-02</b> 9. AGE (In years last birthday) <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bakery Employee</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>GEORGE LAWSON</b>				14. MOTHER'S MAIDEN NAME <b>(DUPLET) Olivia Baublitz</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>21301-3045</b>		17. INFORMANT <b>RECORD'S BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b> <b>519.31-011.9</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory failure</b>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>JULY 25, 1972</b> to <b>AUGUST 24, 1972</b> , that <b>XX</b> (we) last saw the deceased alive on <b>AUGUST 24, 1972</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) <b>(XXXX)</b> view the body after death.							
23A. SIGNATURE <b>Nirmala Mallya</b>				23B. DATE SIGNED <b>08-24-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>NIRMALA MALLYA, M.D.</b>				23D. ADDRESS <b>BALTIMORE MD 21229</b> <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 26, 1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Carroll County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Dorothy M. Hoston</b>		25C. FUNERAL DIRECTOR <b>Eline Funeral Home, Reisterstown, Md. 21136</b>		ADDRESS	

9/20/72 Resp Failure  
Bronchopneumonia  
Chr Obst Pulm Disease  
History of TB

II Chr Alcoholism  
Letter from St. Agnes Hosp. filed  
in Bur. of Biostat - American Bldg  
or

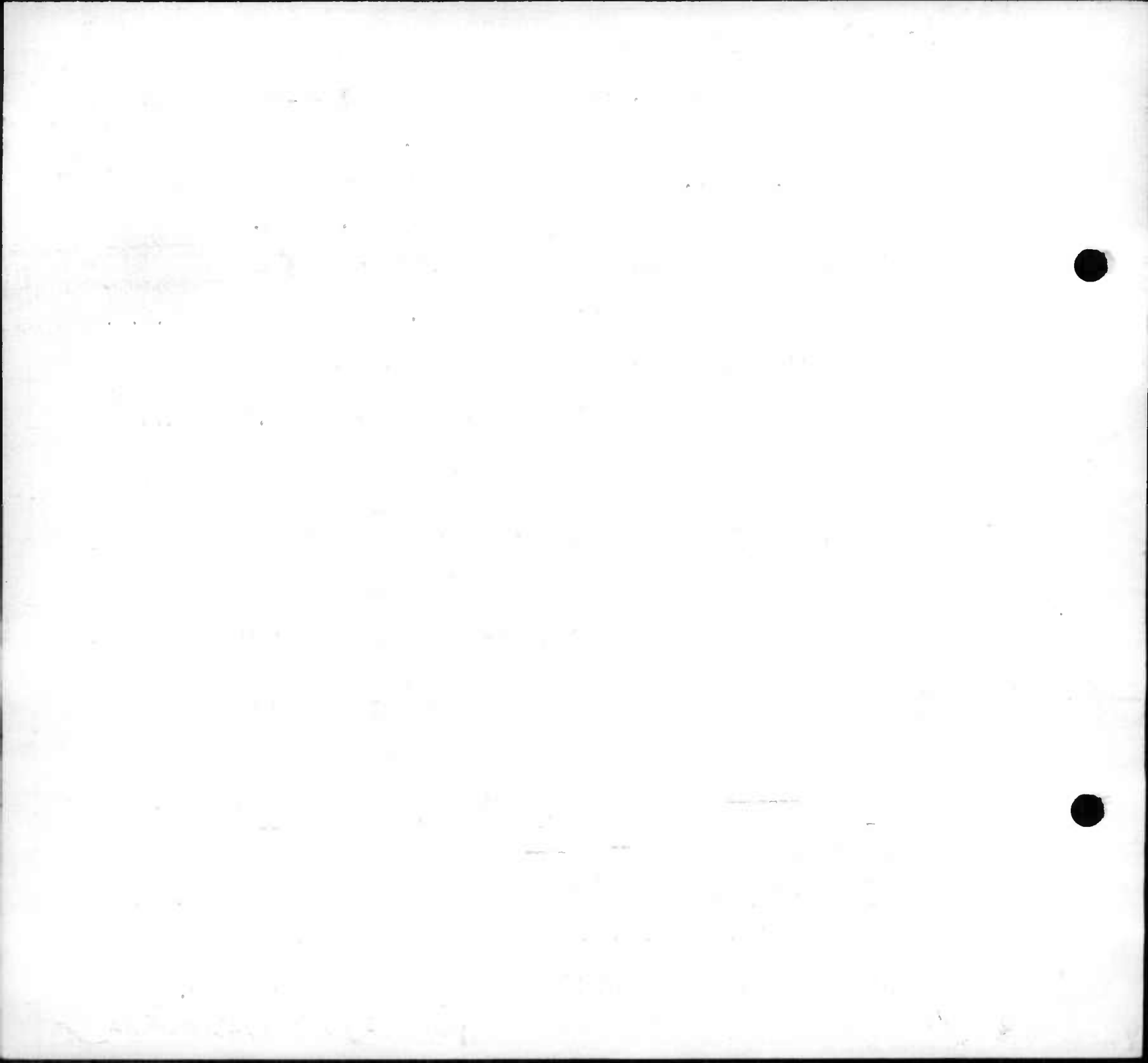


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620		72 08167		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08167	
BIRTH NO.				STATE OF MARYLAND - DEPT			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Gladys A. Brooks				8/24-1972 16:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				A. STATE B. COUNTY			
00 413 E. 31 St.				Md. 1202			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				413 E. 31 St.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8/4.1902	70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Hat Shop		Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Pleasant S. May				Ida Ayers			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		220 14 7174		Frances Del Gaveo		21234 1709 Kennoway	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Chronic obstructive and restrictive lung disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Chronic bronchitis			
				DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Pulmonary fibrosis			
				DUE TO, OR AS A CONSEQUENCE OF:			
				Arteriosclerotic cardiovascular disease			
				15 yrs.			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from April 19 56 to August 24, 1972 that (I) (we) last saw the deceased alive on August 24, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
L. E. Saylor M.D.				Aug. 26, 1972			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Lloyd E. Saylor, M. D.				3902 Greenmount Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/28.72		National Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 28 1972		L. E. Saylor		Frank H. City		8/14/72 36th St	





72 08168

STATE OF MARYLAND-DMH  
BALTIMORE CITY HEALTH DEPARTMENT

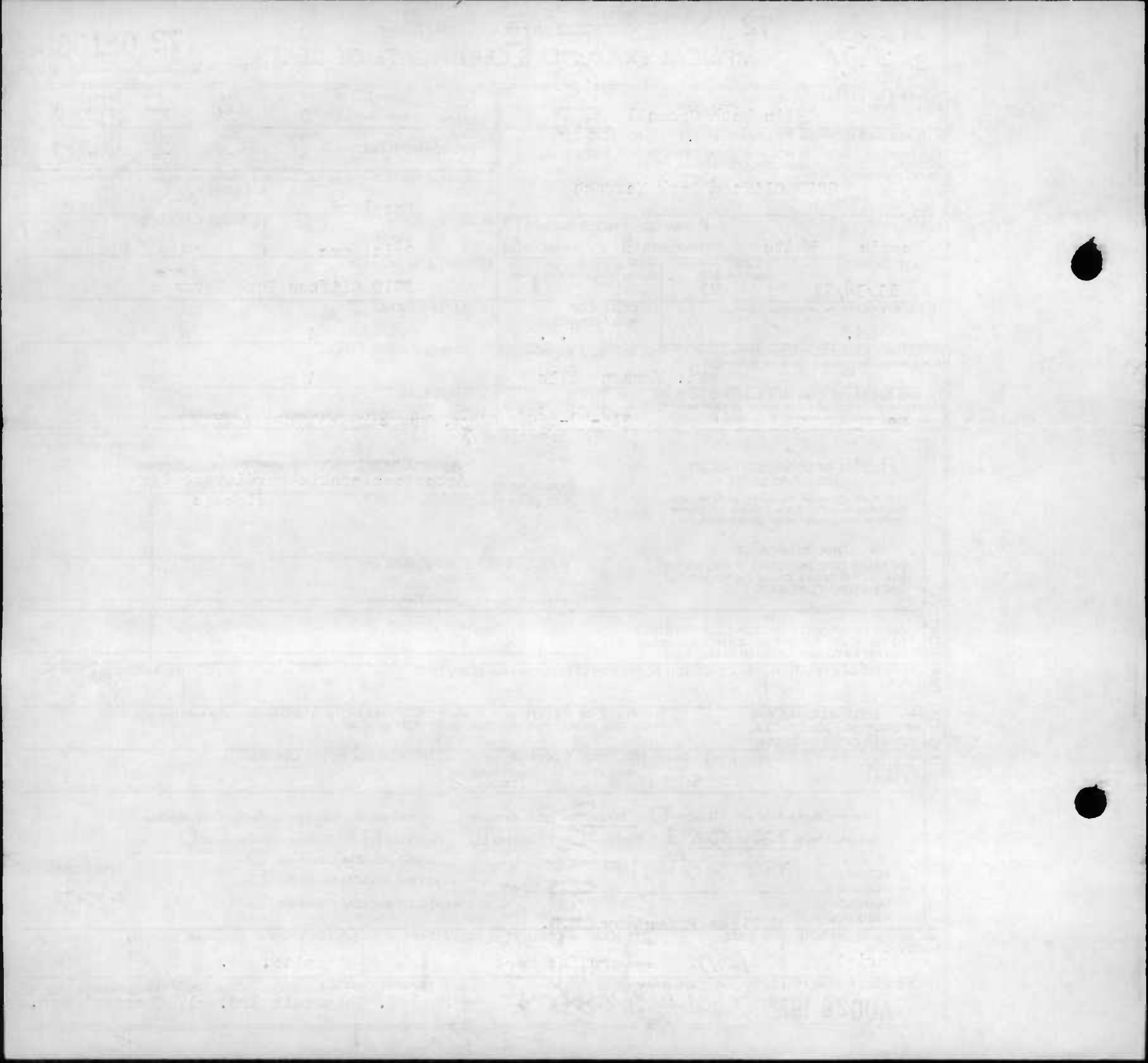
72 08168

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

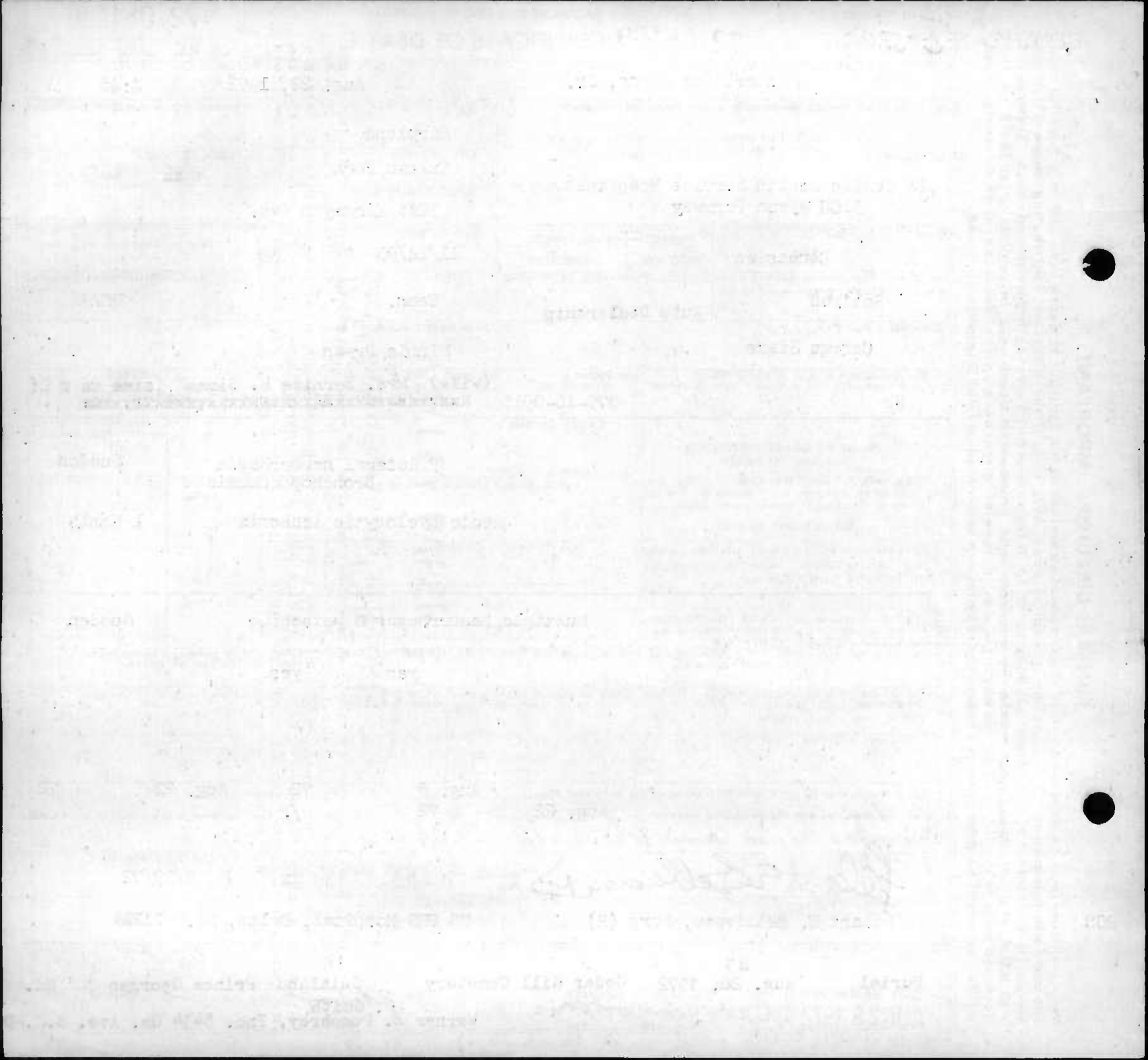
1. NAME OF DECEASED (Type or Print) Elizabeth Gosnell		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 24 72 9:50 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2810 Clifton Park Terrace		3. DATE PRONOUNCED DEAD Month Day Year 8 24 72 9:50 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/18/77		10. AGE (in years lost birthday) 93 74 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY Mt. Vernon Mills	
15. MOTHER'S MAIDEN NAME ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 215-07-6596		18. INFORMANT ADDRESS Mrs. Frances Daveys (same)	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>W P Mulloy</i> M.D. EXAMINER'S NAME (Type): William P. Mulloy, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 8-25-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/28/72	
24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR <i>Andrew Whitton</i>	
25C. FUNERAL DIRECTOR Paul E. Chenoweth		ADDRESS 3rd. 3617 Chestnut Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

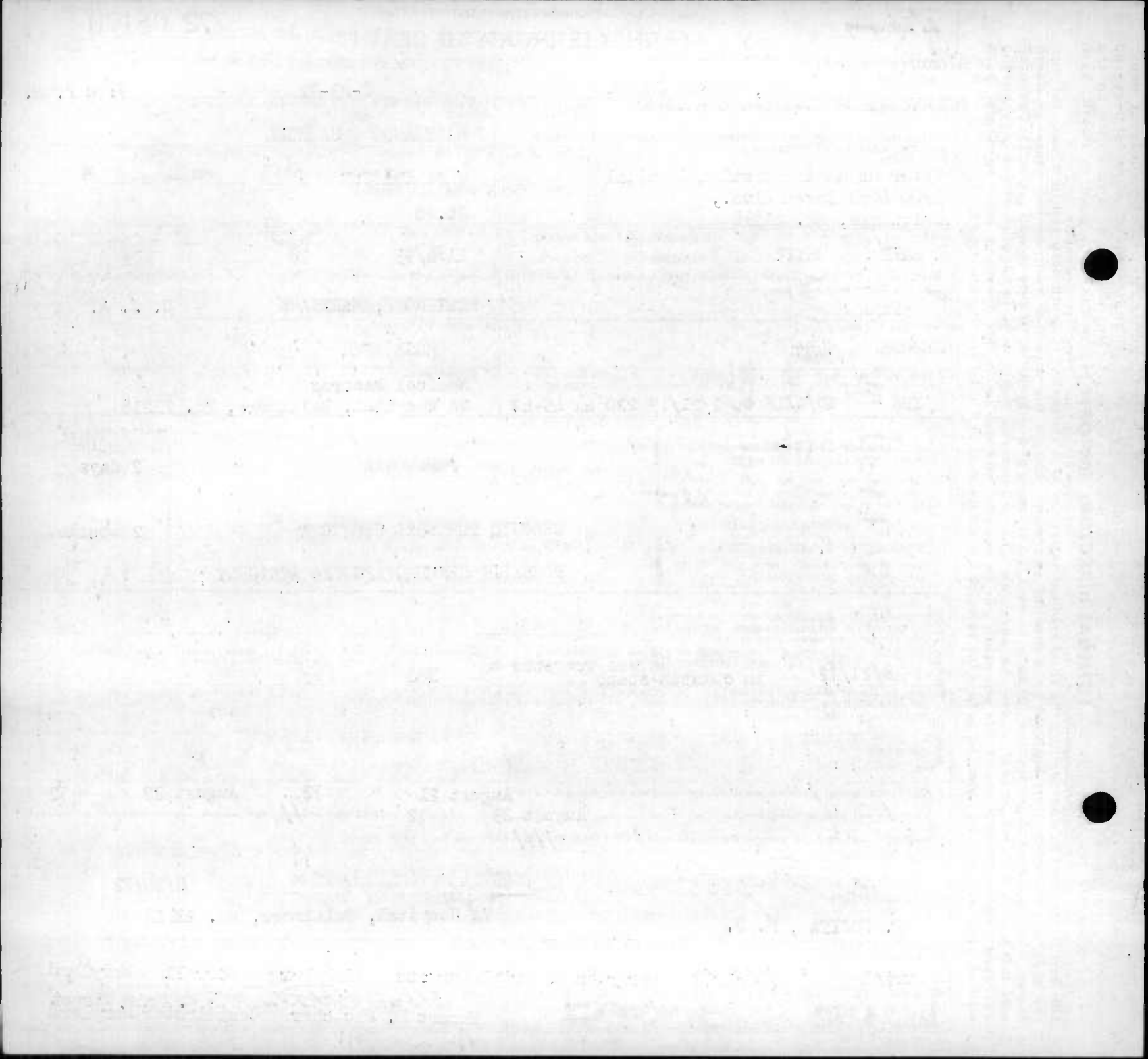
BALTIMORE CITY HEALTH DEPARTMENT				72 08169		72 08169	
BIRTH NO. S-520				CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) Robert Lee Simms, Sr.				2. DATE AND HOUR OF DEATH Aug. 22, 1972 4:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 2x 3100 Wyman Parkway				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland PG 6600			
5. SEX M		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/14/03	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Auto Dealership		9. AGE (In years last birthday) 68		11. BIRTHPLACE (State or foreign country) Tenn.	
13. FATHER'S NAME George Simms				14. MOTHER'S MAIDEN NAME Minnie Bryan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 579-16-0918		17. INFORMANT (wife) Mrs. Bernice E. Simms (same as # C) <del>Robert Lee Simms, Sr.</del>	
18. 20350 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Bilateral hemorrhagic DUE TO, OR AS A CONSEQUENCE OF: bronchopneumonia (B) Acute myelocytic leukemia DUE TO, OR AS A CONSEQUENCE OF: (C) Multiple hemorrhages & petechiae		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 1 Month Sudden	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Multiple hemorrhages & petechiae							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 5 19 72 to Aug. 22 19 72, that (I) (we) last saw the deceased alive on Aug. 22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert E. Belliveau, Surg (R)				23B. DATE SIGNED 8/23/72		23C. PHYSICIAN'S NAME (Type) Robert E. Belliveau, Surg (R)	
23D. ADDRESS US PHS Hospital, Balto, Md. 21211				23E. DATE REC'D BY HEALTH DEPT. AUG 28 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Aug. 26 1972		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Suitland Prince Georges Md.				24E. NAME OF REGISTRAR P. Smith			
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972				25B. NAME OF REGISTRAR P. Smith			
25C. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. MD				25D. ADDRESS Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. MD			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08170</b>	
<b>4-650</b>		<b>72 08170</b>	
BIRTH NO.		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
<b>HORN, GEORGE JOSEPH</b>		<b>8-23-72 7:00 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218</b>		A. STATE <b>MARYLAND</b>	
		B. COUNTY <b>CARROLL</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>WESTMINSTER</b>	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>Rt. 6</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/93</b>
9. AGE (in years last birthday) <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>GEORGE Horn</b>		14. MOTHER'S MAIDEN NAME <b>ROSE AVER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 10/2/18 to 2/21/19</b>		16. SOCIAL SECURITY NO. <b>220 44 45 47</b>	
17. INFORMANT <b>Medical Records VA Hospital, Baltimore, Md. 21218</b>		ADDRESS	
18. <b>4319 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC SUBDURAL HEMATOMA</b>		<b>2 months</b>	
<b>POSSIBLE CEREBROVASCULAR ACCIDENT</b>		<b>2</b>	
<b>II</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>8/21/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>He was operated on in comatose state</b>	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 21 19 72</b> to <b>August 23 19 72</b> , that (I) (we) last saw the deceased alive on <b>August 23 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>K. Fujita</i>		23B. DATE SIGNED <b>8/24/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>K. FUJITA, M. D.</b>		23D. ADDRESS <b>VA Hospital, Baltimore, Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/26/1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Evergreen Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Finksburg Carroll Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <i>Andrew Johnson</i>	
25C. FUNERAL DIRECTOR <b>Thomas D. Fletcher</b>		25D. ADDRESS <b>251 E. Main Street Westminister Maryland</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-400		72 08171		BALTIMORE CITY HEALTH DEPARTMENT		72 08171	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.		STATE OF MARYLAND-DEMR	
1. NAME OF DECEASED (Type or Print) TULL, MARIA				2. DATE AND HOUR OF DEATH 8.24.72 1204 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL 301 SE. PAUL ST.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2814 E. BALTO. MORE ST.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.9.09	9. AGE (In years last birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		
11. BIRTHPLACE (State or foreign country) CAPE CHARLES, VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM GRAY				14. MOTHER'S MAIDEN NAME MARGARET			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT CLARENCE TULL 2814 E. BALTO. ST.	
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Ovarian carcinoma DUE TO, OR AS A CONSEQUENCE OF: with pulmonary metastases (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-8 1972 to 8.24 1972, that (I) (we) last saw the deceased alive on 8.24 1972 and that in (me) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David Shaffer M.D.				23B. DATE SIGNED 8/24/72		23C. PHYSICIAN'S NAME (Type) DAVID SHAFER MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 8/26/72		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM.	
24D. LOCATION (City, town, or county) (State) BALTO, MD.				25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972			
25B. NAME OF REGISTRAR B. DABROWSKI				25C. FUNERAL DIRECTOR 2818 E. BALTO. ST.			

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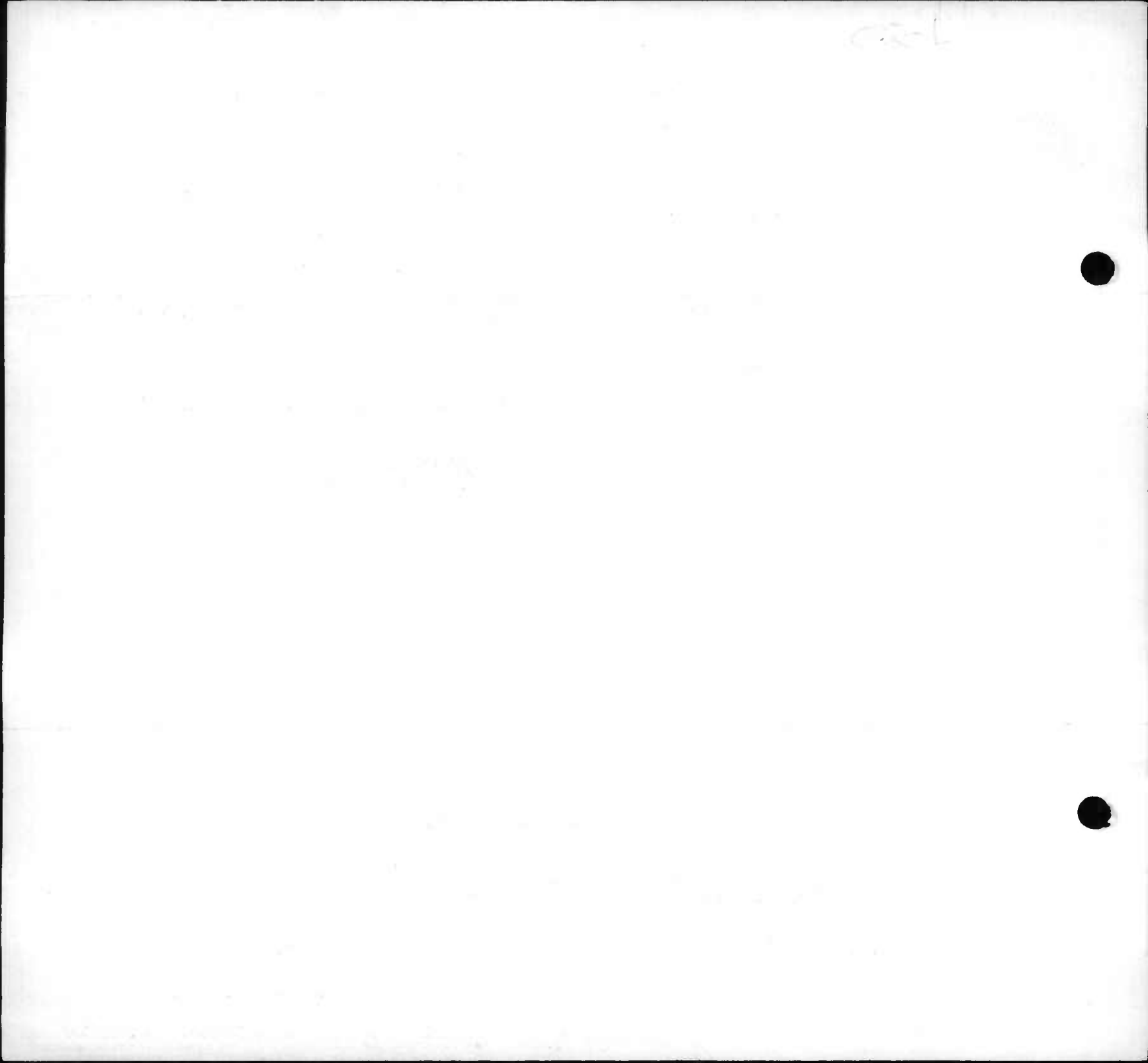
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 08172 STATE OF MARYLAND-DHMH
BIRTH NO. <u>1-520</u>		72 08172		
1. NAME OF DECEASED (Type or Print) <u>SARAH BLANCHE JONES</u>		2. DATE AND HOUR OF DEATH <u>24 August 1972</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>00</u> <u>606 N. East Ave. 21205</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2610</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>606 N. East Ave. 21205</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 July 86</u>	9. AGE (In years last birthday) <u>86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleslady</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Lidard</u>		
14. MOTHER'S MAIDEN NAME <u>Martha Swayne</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>217-18-3197A</u>		17. INFORMANT <u>C. Ruth Leary, 606 N. East Ave. 21205</u>		
18. <u>412.4 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>ASCVD</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____		
22. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>Aug 14</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Charles B. Mac Minn MD</u>		23B. DATE SIGNED <u>Aug 25, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>C.C. MAC MINN MD</u>
23D. ADDRESS <u>2900 E. Baltimore St. 21205</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		
24B. DATE <u>28 Aug 72</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Co., Md. 21224</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>		25B. NAME OF REGISTRAR <u>Audrey B. Weston</u>		25C. FUNERAL DIRECTOR <u>Ullrich Funeral Home, Balto., Md. 21206</u>



## CERTIFICATE OF DEATH

REG. NO.

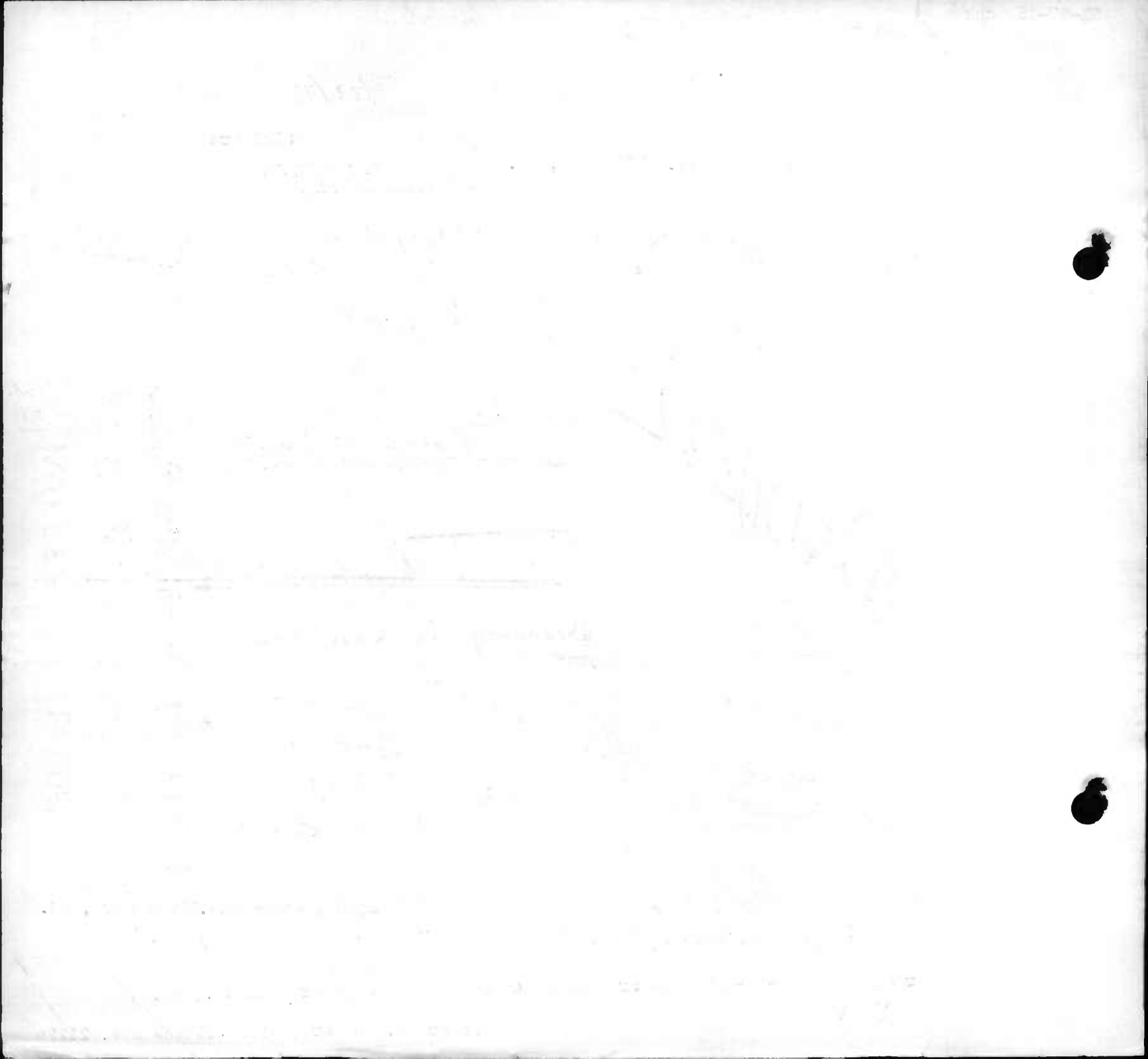
72 08173

STATE OF MARYLAND-DMMR

7-425		72 08173		72 08173	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William O. Faulkner		2. DATE AND HOUR OF DEATH 8/22/72 6 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore		5. CITY OR TOWN CATONSVILLE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 Eastern Ave. Baltimore, Md.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 921 Kent Avenue	
6. SEX Male	7. RACE WHITE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 12/11/99	10. AGE (In years last birthday) 72	11. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Clerk)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME NATHAN Faulkner		14. MOTHER'S MAIDEN NAME Ella Schools	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 2610 3326		17. INFORMANT (brother) EARL Faulkner	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) Burns of Chest		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sudden Death		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins.	
21. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Bronchogenic Carcinoma		(B) DUE TO, OR AS A CONSEQUENCE OF: 4 wks		(C) DUE TO, OR AS A CONSEQUENCE OF: Histiocytic Blastoma 26 month	
19A. DATE OF OPERATION 7-27-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Mt Wilson State Hosp.	
21D. TIME OF INJURY (Approx.) 7-27-72 5 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Smoking in bed, clothes caught fire	
22. I certify that (1) (this hospital) attended the deceased from 28 July 1972 to 22 August 1972 and that (2) (we) last saw the deceased alive on 22 Aug 1972 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas W. Lawhorne, Jr. M.D.		23B. DATE SIGNED 8/22/72		23C. PHYSICIAN'S NAME (Type) THOMAS W. LAWHORNE, JR. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-26-1972		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Anne Arundel Co., Md.		25A. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25B. ADDRESS	

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08174</u>
72 08174 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEPT
BIRTH NO. <u>C-620</u>		1. NAME OF DECEASED (Type or Print) <u>XXXXXXXXXXXXXXXXXXXX ADAM D. CRAIG</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>August 22, 1972</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>President Hospital Inc.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1538</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2803 GARRISON BLVD. 21216</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07-02-01</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <u>71</u>
		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles L. Craig</u>		14. MOTHER'S MAIDEN NAME <u>Katie A. Bryson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. GEORGE KESSLER</u> ADDRESS <u>1247 LINDEN AVE</u>
18. <u>441.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Possible Ruptured Aortic Arch Aneurysm</u>		
ANTECEDENT CAUSES		(B) <u>Atherosclerotic Cardiovascular Disease</u>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 22</u> 19 <u>72</u> to <u>August 22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>August 22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Virginia F. Mercado, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8-22-72</u>
23C. PHYSICIAN'S NAME (Type) <u>VIRGINIA F. MERCADO, M.D.</u>		23D. ADDRESS <u>President Hospital Inc.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-25-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>
				24D. LOCATION <u>Glen Burnie, Anne Arundel Co., Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>



11/14/70 from Cooper Conv. Home.

BIRTH NO.		72 08175		BALTIMORE CITY HEALTH DEPARTMENT		72 08175	
1. NAME OF DECEASED (Type or Print)		R. GEORGE NIXON		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month Day Year Hour August 22, 1972 8:40 A. M.	
708 Cathedral Street, Room 507				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Maryland B. COUNTY 1102	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Male	White			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		E. STREET AND NUMBER			
April 19, 1925		47 502		708 Cathedral Street			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
Florida		U.S.A.		William Nixon			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
Upholstery				Lela Gousbly			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
Yes WW 11				Mrs Lois Gordon		Mobile Ala.	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes (partial)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/28/72		Good Hope		Baker Florida	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 28 1972		Sidney J. Houston		Leonard J Ruck Inc.		Baltimore, Md	

100-100000

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

TO THE HONORABLE ATTORNEY GENERAL

FROM THE DIRECTOR, FBI

RE: [Illegible]

DATE: [Illegible]

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

(Initials)

(Signature)

Special Agent in Charge

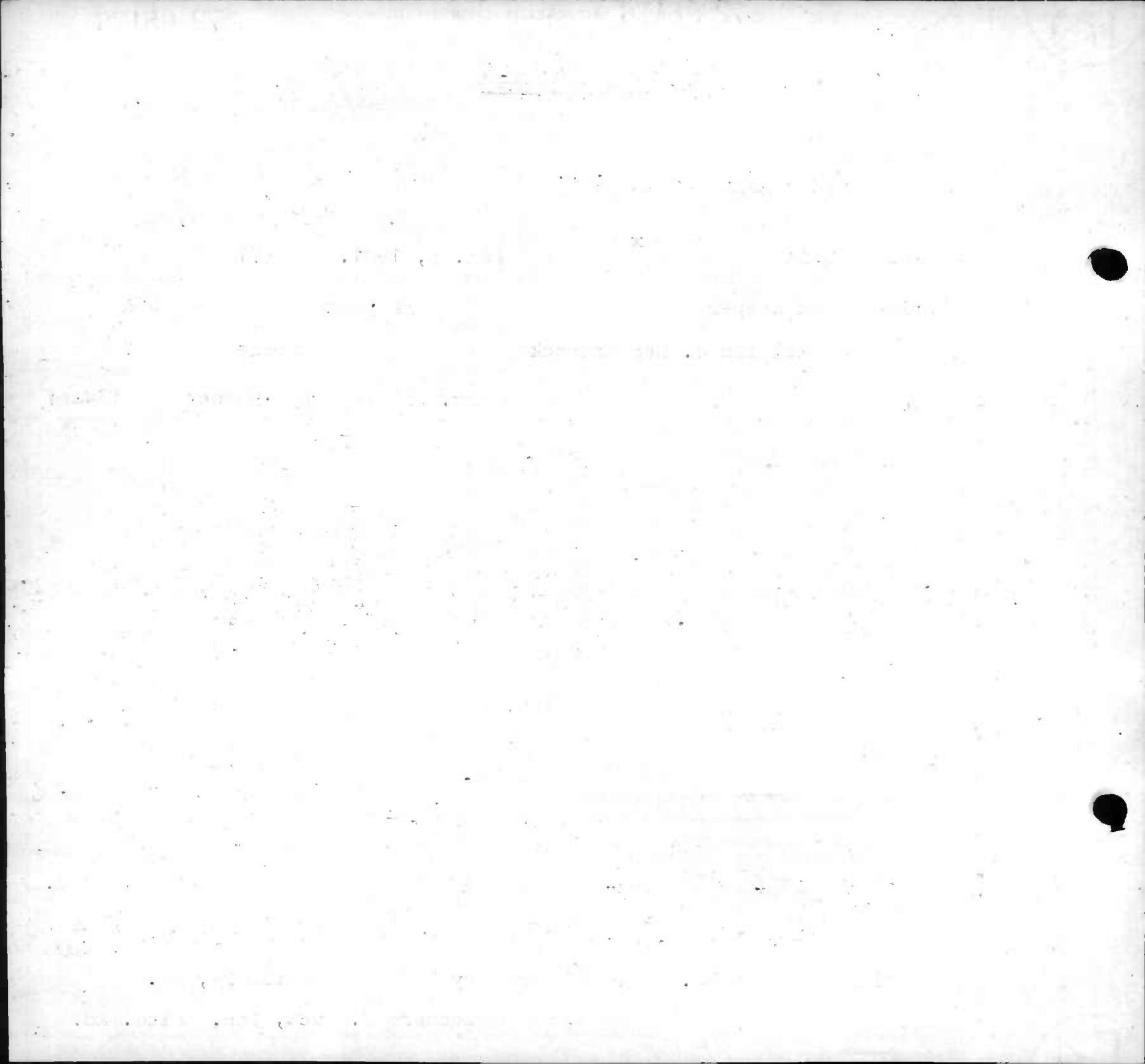
Very truly yours,

Enclosed, please find

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-151		72 08176		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08176	
BIRTH NO.				STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or print) WILLIAM T. DEPPENBROCK				2. DATE AND HOUR OF DEATH 8/24/72 9:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2745			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 6001 BURGESS AVE.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6001 BURGESS AVE.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 5, 1901	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Book Keeper				10B. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Deppenbrock				14. MOTHER'S MAIDEN NAME Carrie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mildred Deppenbrock		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH AS CVD. acute MI (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: after arthritis - cervical (B) DUE TO, OR AS A CONSEQUENCE OF: Spinal Stenosis + Cervical Cord Pressure. (C) Spinal Stenosis OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Spinal Stenosis 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 15 1968 to Aug 24 1972 that (I) was last saw the deceased alive on Aug 24 1972 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald W. Montzer				23B. DATE SIGNED 8/24/72		23C. PHYSICIAN'S NAME (Type) DONALD W. MONTZER	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/28/72		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR Sidney H. Ruck		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08177	
T-612 72 08177				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>MARGARET E. TRAVIS</b>			2. DATE AND HOUR OF DEATH <b>AUG 24, 1972 11:42 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2102</b>		
5. SEX <b>F</b>			6. RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		8. DATE OF BIRTH <b>4/28/1907</b>
13. FATHER'S NAME <b>Charles E. Burns</b>			14. MOTHER'S MAIDEN NAME <b>Cora Coffman</b>		9. AGE (In years last birthday) <b>65</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
17. INFORMANT <b>Mr. Oliver D. Travis</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
18. <b>412.43.250.9</b>			ADDRESS <b>1337 Sargeant St.</b>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE <b>CARDIOGENIC SHOCK</b>			<b>6 HRS.</b>		
(B) INTRACTABLE CONGESTIVE HEART FAILURE			<b>3 WEEKS</b>		
(C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			<b>SEVERAL YRS.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES MELLITUS</b>			<b>SEVERAL YRS.</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <b>8/24 19 72</b> to <b>8/24 19 72</b> , that (I) ( <u>we</u> ) last saw the deceased alive on <b>8/24 19 72</b> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>We</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <b>Robert J. Bauer, M.D.</b>				23B. DATE SIGNED <b>8/24/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT J. BAUER, M.D.</b>				23D. ADDRESS <b>3001 S. HANOVER ST. BALTIMORE, MD. 21230</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>8/28/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Cloness, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Hinton</b>	
25C. FUNERAL DIRECTOR <b>John J. Bowman &amp; Son Inc.</b>		25D. ADDRESS <b>Hollins St. 21223</b>			

REPORT OF BOARD OF DIRECTORS  
FOR THE YEAR 1904

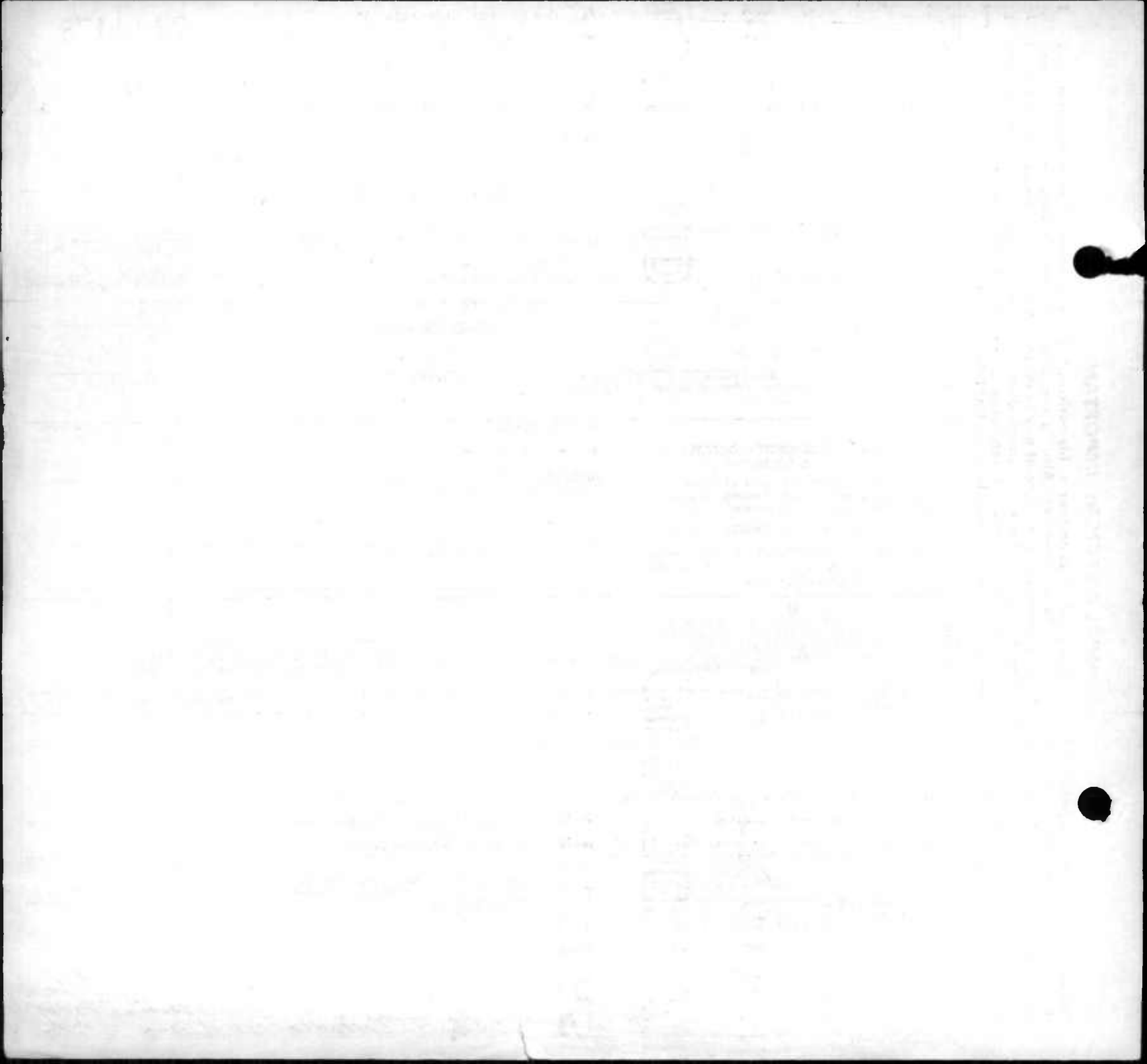
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

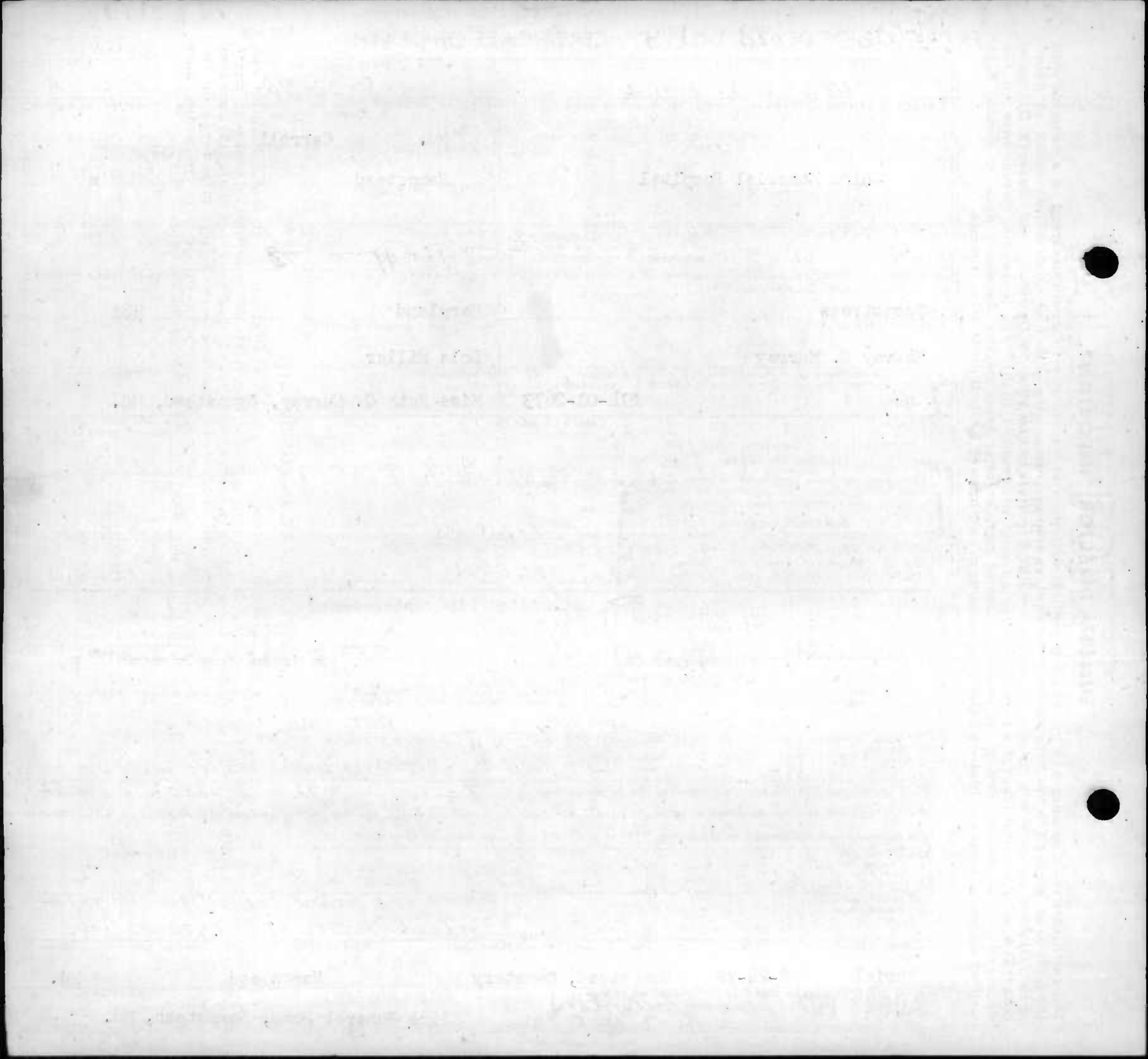
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08178</b>
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEHMD
BIRTH NO. <b>L-52 12-1282172</b>		DEATH NO. <b>72 08178</b>		
1. NAME OF DECEASED (Type or Print) <b>GARY MICHAEL LANKFORD</b>		2. DATE AND HOUR OF DEATH <b>8/24/72 8:15 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b> <b>601 N. BROADWAY</b> <b>BALTIMORE, MARYLAND</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>ANARUNDEL</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>SEVERNA PARK</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>M</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 AUG 1972</b>		9. AGE (in years last birthday) <b>2</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALT. BON SECOURS HOSP. MD</b>
13. FATHER'S NAME <b>THOMAS LANKFORD, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>HILDA LUKENICH</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>FATHER</b>
				ADDRESS <b>SAME AS ABOVE</b>
18. <b>746.1 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<b>CARDIAC FAILURE - HYPOXIA</b>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		<b>TRANSPOSITION OF THE GREAT VESSELS</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>8/23 1972</b> to <b>8/24 1972</b> that (I) (we) last saw the deceased alive on <b>8/24 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>J. E. Graeber M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/24/72</b>
23C. PHYSICIAN'S NAME (Type) <b>Janet E. Graeber M.D.</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/26/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery Glen Burnie MD</b>
24D. LOCATION (City, town, or county) (State) <b>Severna Park Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Barlow</b>
25C. FUNERAL DIRECTOR <b>Robert E. Barlow</b>		ADDRESS <b>Severna Park Md.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		72 08179		BALTIMORE CITY HEALTH DEPARTMENT		7208179		X		REG. NO.	
BIRTH NO.		72 08179		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEATH					
1. NAME OF DECEASED (Type or Print) <b>HELEN V. MURRAY</b>				2. DATE AND HOUR OF DEATH <b>8-22-72 1:30 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b> <b>44</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Carroll</b> <b>5600</b>				C. CITY OR TOWN <b>Hampstead</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-16-99</b>		9. AGE (In years last birthday) <b>73</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harvey E. Murray</b>				14. MOTHER'S MAIDEN NAME <b>Lola Miller</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, ne or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-01-2673</b>		17. INFORMANT <b>Miss Ruth C. Murray, Hampstead, Md.</b>				ADDRESS	
18. <b>E 9301</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Acute hepatic failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hepatitis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>operation</b> <b>Rt. total hip replacement</b> <b>operation</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>79 days</b> <b>9 days</b> <b>19 days</b>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>8-3-72</b> 19B. CONDITION OF WHICH OPERATION WAS PERFORMED <b>Rt. total hip replacement</b> 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <b>N.A.</b> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital (A.S.)</b> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>XXXX Union Memorial</b> <b>12-02</b>											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>8/3/72 N.A.</b> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? <b>Hepatitis complication - Halothane anaes.</b>											
22. I certify that (I) (this hospital) attended the deceased from <b>8-19</b> 19 <b>72</b> to <b>8-22</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>8-22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Tadashi Kuba</b> DEGREE <b>Attending Phys.</b> <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED <b>8-22-72</b>				23C. PHYSICIAN'S NAME (Type) <b>THE UNION MEMORIAL HOSPITAL</b>				23D. ADDRESS <b>33rd and CALVERT ST. BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hampstead Cemetery</b>		24D. LOCATION (City, town, or county) <b>Hampstead Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>				25B. NAME OF REGISTRAR <b>Andrew H. Horton</b>		25C. FUNERAL DIRECTOR <b>Eline Funeral Home, Hampstead, Md.</b>				ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08180		REG. NO. 72 08180	
M-240 72 08180 CERTIFICATE OF DEATH							
BIRTH NO. <u>68-17906</u>		1. NAME OF DECEASED (Type or Print) <u>BOONIE M. McCALL</u>					
2. DATE AND HOUR OF DEATH <u>AUG 25 1972 2:45 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH 43</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE GENERAL HOSP</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2403</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-24-68</u> 9. AGE (In years last birthday) <u>3 years</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PRENTIS R. McCALL</u>				14. MOTHER'S MAIDEN NAME <u>BETTY McCAFFREY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>Prentis-McCall - same as #4</u> ADDRESS <u>#4</u>			
18. <u>285.91</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE <u>Congestive Heart Failure</u>					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(B) <u>Severe anemia</u>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:					
II		(C) <u>12 days post birth pt. had a C.S.F. shunt implanted for</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>meningococci &amp; Hydrocephalus Spina Bifida</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>AUG 23</u> 19 <u>72</u> to <u>AUG 25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>AUG 25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Theresa A. Beltran, M.D.</u>				23B. DATE SIGNED <u>AUG 25, 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>	
23D. ADDRESS <u>DEGREE</u>				23E. FUNERAL DIRECTOR <u>McCall</u>		23F. ADDRESS <u>130 E. Fort Ave. Balto. 21230</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-28-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>		25B. NAME OF REGISTRAR <u>Audrey H. H. H.</u>		25C. FUNERAL DIRECTOR <u>McCall</u>		25D. ADDRESS <u>130 E. Fort Ave. Balto. 21230</u>	

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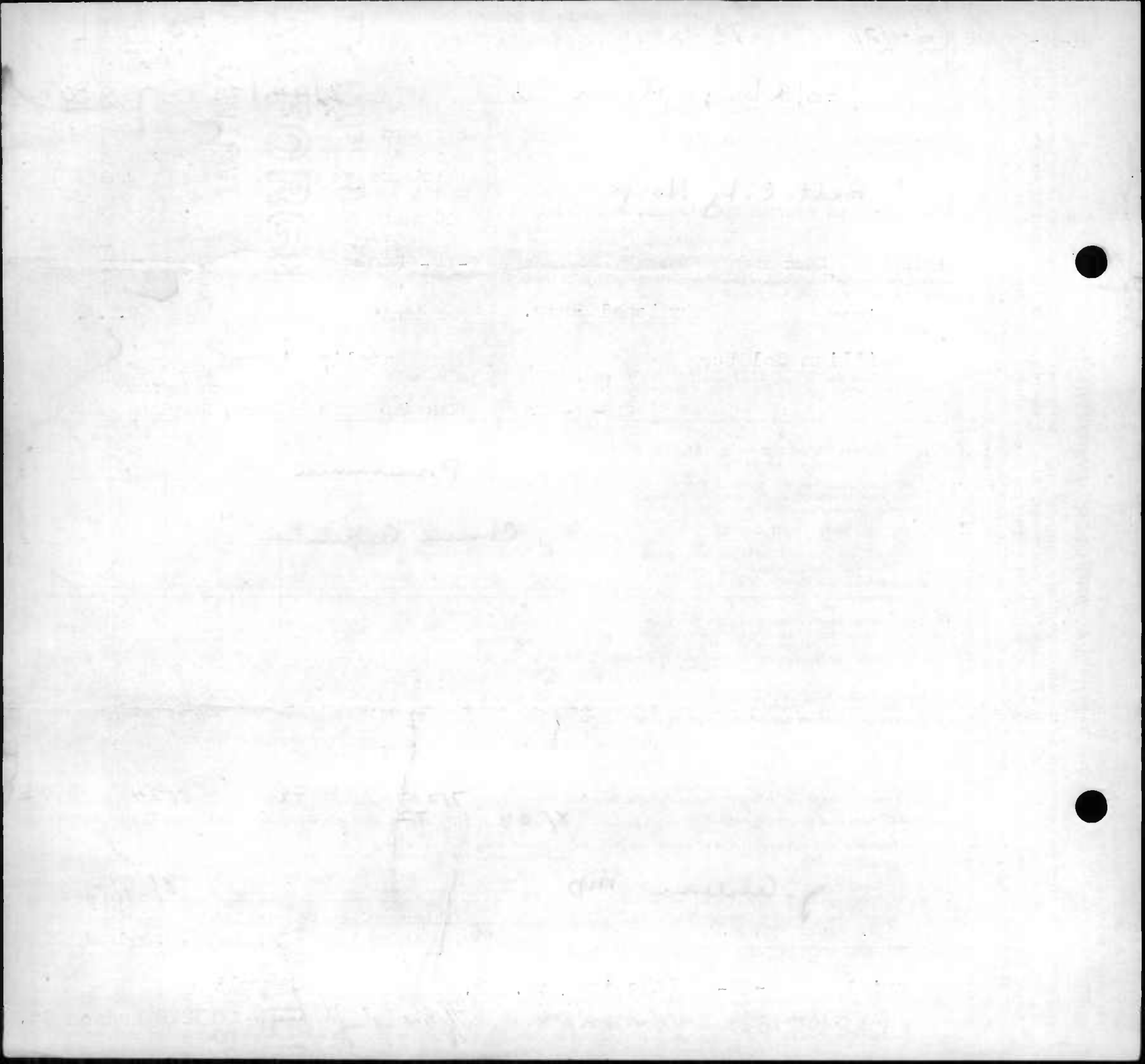
61-5526 djr

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08181	
72 08181				STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <b>Goldburn, John J.</b>			2. DATE AND HOUR OF DEATH <b>8/24/72 8:30 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Balt. City Hosps.</b> <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>101</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>916 South Decker Avenue 21224</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-1899</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>National Brew.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William Goldburn</b>		
14. MOTHER'S MAIDEN NAME <b>Natalia Zinkand</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>216-05-4226</b>			17. INFORMANT <b>BCH: RECORDS Baltimore, Maryland 21224</b>		
18. CAUSE OF DEATH I <b>#86X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>2</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>2</b> 20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour) <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
22. I certify that (I) (this hospital) attended the deceased from <b>7/25</b> 19 <b>72</b> to <b>8/24</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Anderson mb</b>			23B. DATE SIGNED <b>8/24/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>J. Anderson, M.D;</b>			23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>8-28-72</b>	24C. NAME of CEMETERY or CREMATORY <b>LakeView Mem. Pk.</b>	24D. LOCATION (City, town, or county) (State) <b>Carroll Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Hinton</b>		25C. FUNERAL DIRECTOR <b>Helma A. Hoffman</b>	
				ADDRESS <b>3218 Hudson St.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08182</b>	
<b>72 08182</b>				<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Amelia A Johnston</b>		2. DATE AND HOUR OF DEATH <b>August 22, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>1106 Seaboard Court</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2505</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1106 Seaboard Ct.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/18/86</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York, NY</b>	
13. FATHER'S NAME <b>Houck</b>		14. MOTHER'S MAIDEN NAME <b>Anna T.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Millie Pugh 1407 Houghton Road</b>	
18. <b>410-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction Sudden</b> (B) <b>ASCD E C.H.F.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>years.</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-8-</b> <b>1969</b> to <b>8-22-</b> <b>1972</b> , that (I) (we) last saw the deceased alive on <b>7-24-</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Jack I. Stern, M.D.</b>				23B. DATE SIGNED <b>8-22-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jack I. Stern, M.D.</b>				23D. ADDRESS <b>300 Hospital Drive, Glen Burnie, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/25/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Glen Burnie, Maryland</b>		24E. (State) <b>Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>	
25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		25D. ADDRESS <b>4001 Ritchie Highway</b>	

100



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08183		C-560	
BIRTH NO.		REG. NO.		72 08183	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEMD	
Conroy, Anna S.		8/21/72		6:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Edgewood Nursing Home 6000 Belknap Ave. Balto. Md. - 21212		B. COUNTY		Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Homemaker				7/13/91	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
John Grady		Mary Nolan		81	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		212-03-9038B		Eugene A. Conroy 3026 Barclay Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
437.9 I		Cerebral Arteriosclerosis -			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) General Arteriosclerosis -			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/30/72 to 8/21/72 that (I) (we) last saw the deceased alive on 8/21/72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Anthony F. Carotta		8/22/72		Anthony F. Carotta	
23D. ADDRESS		23E. ADDRESS		23F. ADDRESS	
5217 York Rd Balto Md 21212		5217 York Rd Balto Md 21212		5217 York Rd Balto Md 21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8/24/72		New Cathedral	
24D. LOCATION		24E. LOCATION		24F. LOCATION	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 28 1972		Anthony F. Carotta		Mitchell-Wiedefeld-Home 6500 York Rd	

1919

Small paper  
Xerox

18

18/11/1

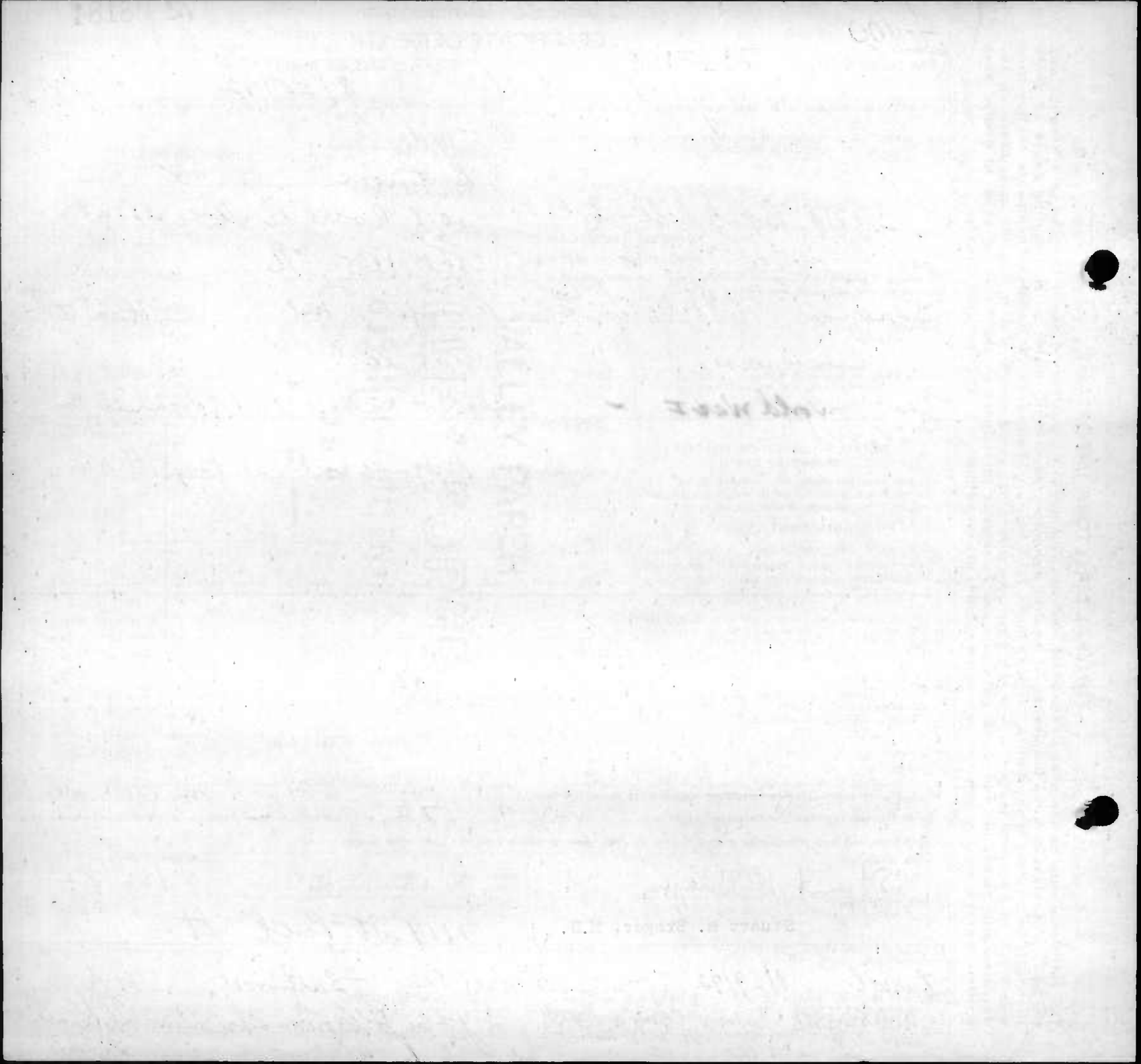
1919

18/11/1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08184	
H-400				72 08184	
BIRTH NO.				72 08184	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
George D. Hall				8/25/72 9:25 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
1018 Rockhill Ave				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday)	
Male White				Oct 18 1895 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
Semen				Annapolis, Md.	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
Telephone Co.				U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Unknown				Fannie?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
Yes. World War I				17. INFORMANT ADDRESS 21229	
18. 162.1 I				Robert P. Hall 1018 Rockhill Ave	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ADENOCARCINOMA OF LUNG				4 mos	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0				20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 19 64 to Aug 25 1972, that (I) (we) lost saw the deceased alive on July 7 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Stuart H. Brager, M.D.				8/26/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Stuart H. Brager, M.D.				1114 St. Paul St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/29/72		New Cathedral Cn.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 28 1972		John J. Brown & Son Inc.		25D. LOCATION (City, town, or county) (State)	
25E. ADDRESS		25F. ADDRESS			
21223		21223			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

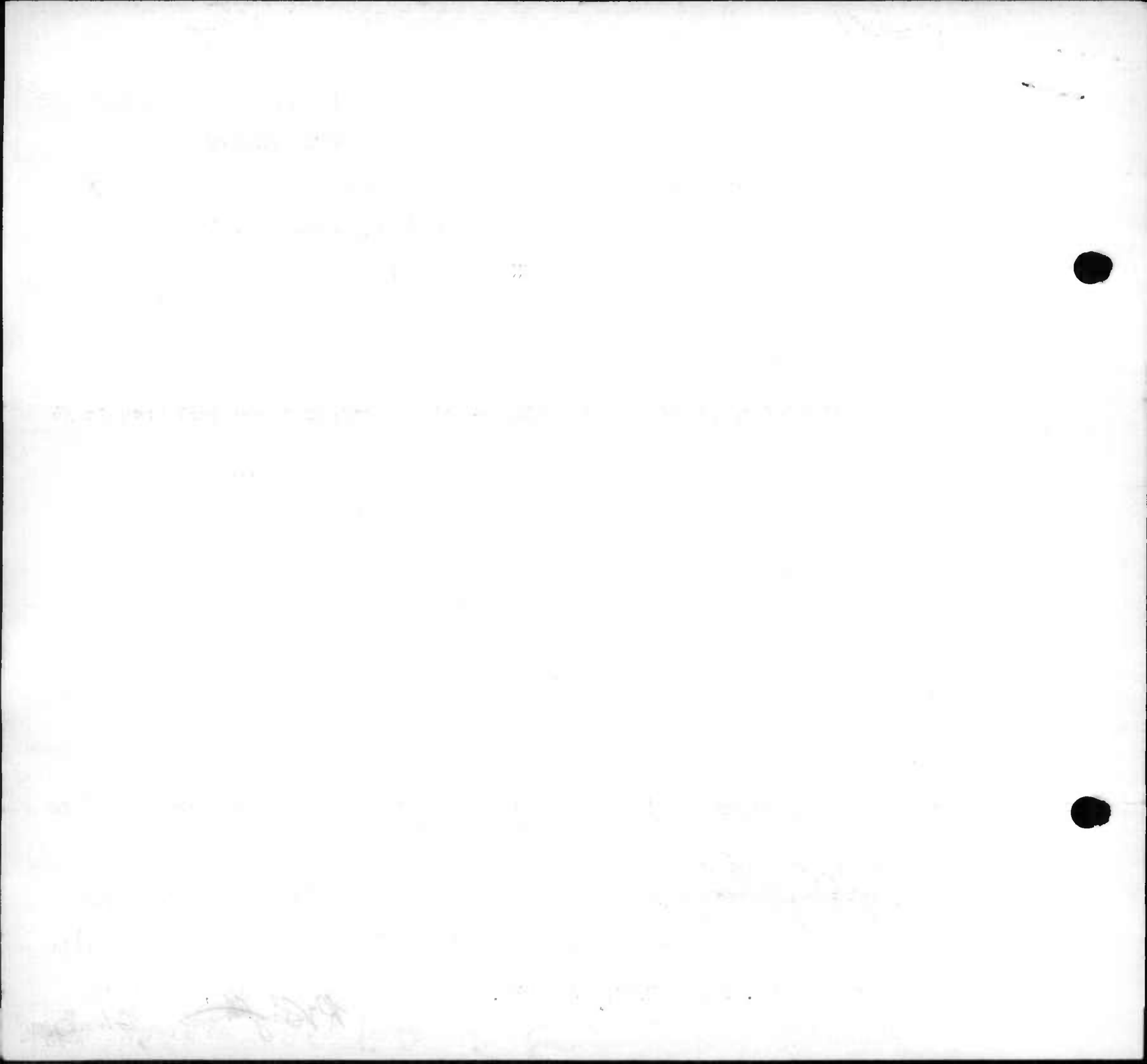
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08185</b>	
BIRTH NO. <b>W-123</b>		72 08185		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>Webster, Mary K.</b>			2. DATE AND HOUR OF DEATH <b>8-20-72</b> <b>12:55 P</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>John's Hopkins Hospital</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2749</b>		
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>08/29/86</b>		9. AGE (In years, last birthday) <b>85 (85)</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		
11. BIRTHPLACE (State or foreign country) <b>Railroad, Pa</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Washua MC ABBE</b>			14. MOTHER'S MAIDEN NAME <b>Susan Shearer</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212 05 0595</b>		
17. INFORMANT <b>Howard H. Miller</b>			ADDRESS <b>1538 Cold Spring Lane, Baltimore, Md. 21218</b>		
18. <b>250.91</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Myocardial Infarction</b> <b>48 hr.</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Diabetes Mellitus</b> <b>14 yrs</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Coronary artery atherosclerosis</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>7</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-19</b> <b>1972</b> to <b>8-20</b> <b>1972</b> that (I) (we) last saw the deceased alive on <b>8-20</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harry R. Jacobson M.D.</b>				23B. DATE SIGNED <b>8/20/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harry R. Jacobson</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug 23/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Freedom Cemetery</b>	
24D. LOCATION (City, town, or county) <b>New Freedom, Pa.</b>		(State) <b>Pa.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Adrian Whitton</b>		25C. FUNERAL DIRECTOR <b>James J. Kastensten</b>	
ADDRESS <b>New Freedom, Pa.</b>					

THE JOHN HOPKINS HOSPITAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 08186	
1. NAME OF DECEASED (Type or Print) <b>BASS EVELYN M.</b>				2. DATE AND HOUR OF DEATH <b>8/26/72 10400 HRS.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MD. HOSPITAL</b> <b>38</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN <b>GLEN BURNIE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>114 THIRD AVE S.W.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>6-19-17</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES MIEKSCH</b>				14. MOTHER'S MAIDEN NAME <b>EDNA SCHNAPPINGER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218 18 5138</b>		17. INFORMANT <b>Bonnie Rosenauer (daughter)</b> Same As #4			
18. <b>162.1 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY CARCINOMA</b> WITH WIDESPREAD METASTASES ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11 AUGUST 19 72</b> to <b>26 AUGUST 19 72</b> that (I) (we) last saw the deceased alive on <b>25 AUGUST 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Wolfe Blotzer</b> MD DEGREE				23B. DATE SIGNED <b>8-26-72</b>		23C. PHYSICIAN'S NAME (Type) <b>WOLFE BLOTZER MD</b> DEGREE	
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug. 29/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN MEM. PARK</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Jackson</b>		25C. FUNERAL DIRECTOR <b>Singleton Funeral Home, Glen Burnie, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08187		72 08187	
BIRTH NO. 11-436				72 08187		72 08187	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		REG. NO.	
ELEANOR D. WALTERS				08-24-72		7:17 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MARYLAND		B. COUNTY FREDERICK	
THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN FREDERICK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1406 N. MARKET ST.							
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-21-04	
9. AGE (In years last birthday) 68		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) New York City, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owned Business				10B. KIND OF BUSINESS OR INDUSTRY Hat Designer			
13. FATHER'S NAME REGINALD EARLE DUNNE				14. MOTHER'S MAIDEN NAME ANNE DOLAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 234-44-6260		17. INFORMANT Mr. Harold L. Walters, Jr. Rt. #2 Frederick, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPSIS, GRAM NEGATIVE CHRONIC HEPATIC AND RENAL FAILURE (B) DUE TO, OR AS A CONSEQUENCE OF: CIRRHOSIS, BLEEDING VARICES (C) LAENNEC'S			
19. DATE OF OPERATION 3/31/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BLEEDING ESOPHAGEAL VARICES			
20A. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8/1 1972 to 8/24 1972 that (I) (we) lost saw the deceased alive on 8/24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Reginald G. Cohen MD				23B. DATE SIGNED 8/24/72			
23C. PHYSICIAN'S NAME (Type) REGINALD COHEN MD				23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/26/72		24C. NAME OF CEMETERY or CREMATORY Resthaven Memorial Gardens		24D. LOCATION (City, town, or county) (State) Frederick Frederick Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR Sidney M. Cohen		25C. FUNERAL DIRECTOR SMITH, FADELEY, KEENEY, BASFORD FUNERAL HOME 1406 E. Church St. Frederick, Md. 21701			

RECEIVED

NOV 12 1964

U.S. DEPARTMENT OF JUSTICE

WHITE

NOV 12 1964

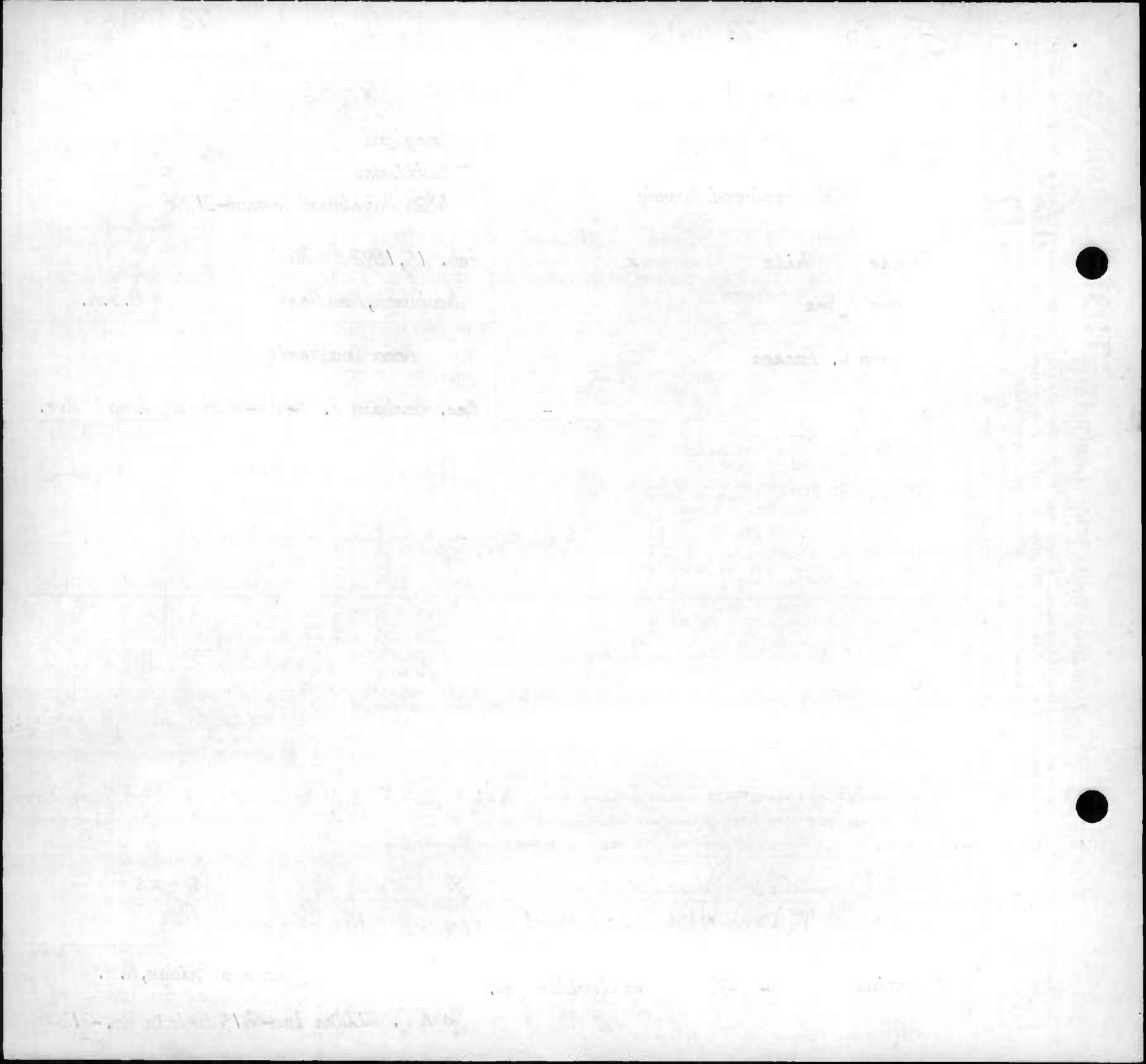
RECEIVED NOV 12 1964

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 08188</span>	
E-333 72 08188				STATE OF MARYLAND-DEMT	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Susan F Eastwood		8-25-72 8 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
90 4826 Hazelwood Avenue				Maryland 2631	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4826 Hazelwood Avenue-21206	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years lost birthday)
Female	White			Feb. 15, 1892	80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Home Maker					Newburgh, New York
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John G. Farrer			Anna Dougherty		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Mrs. Barbara E. Peake-4826 Hazelwood Ave.
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I				1 year	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				Heart failure	
ANTECEDENT CAUSES				(B) Coronary artery disease	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug. 25 1972 to Aug. 25 1972 that (I) (we) last saw the deceased alive on _____ 19 _____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
R Donald Jandorf				8-25-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
R Donald Jandorf				7403 Harford Rd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-29-72		Kettleville Cem.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 28 1972		Sidney H. Hooton		John C. Miller Inc-6415 Belair Rd.-21206	

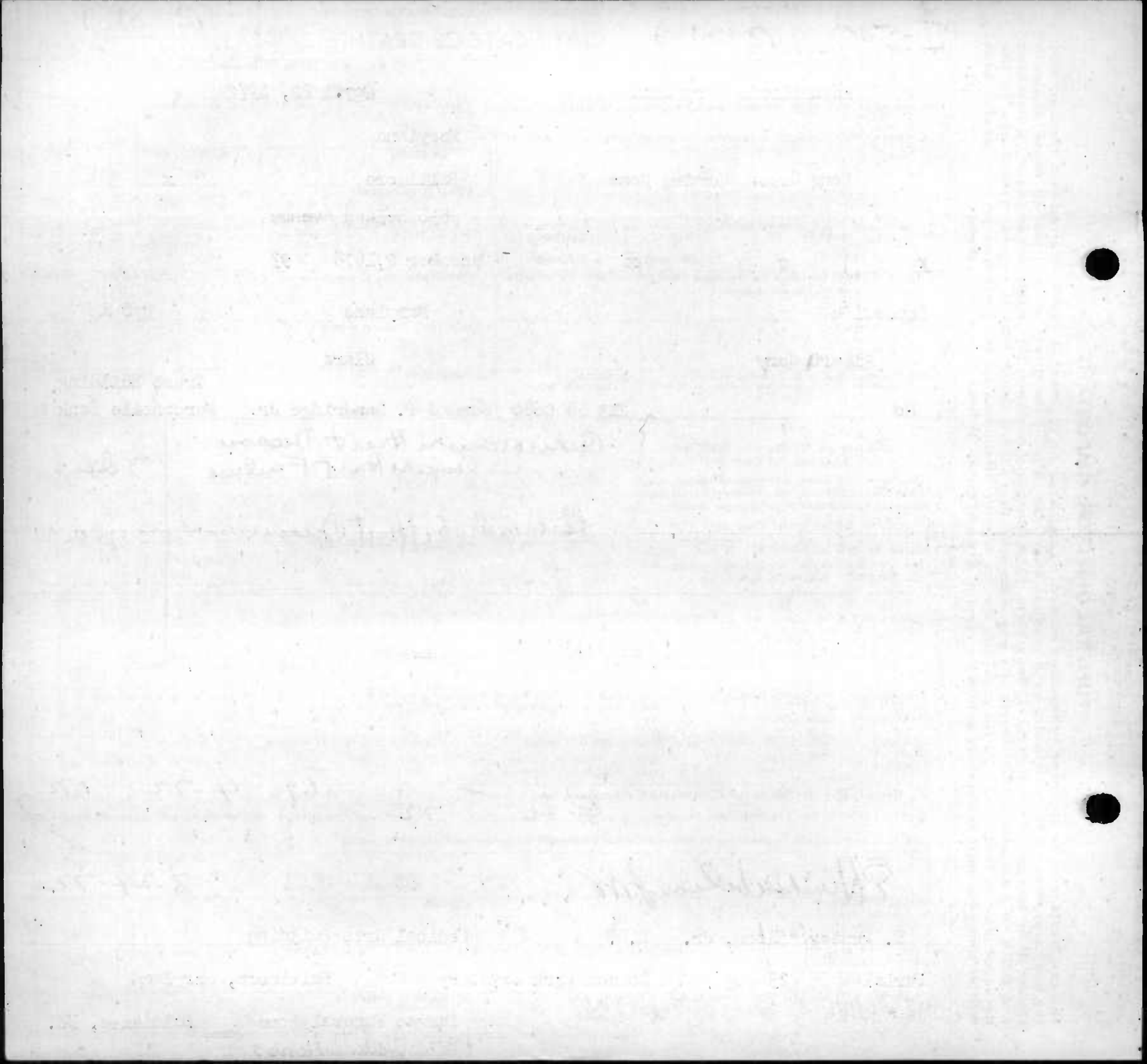




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

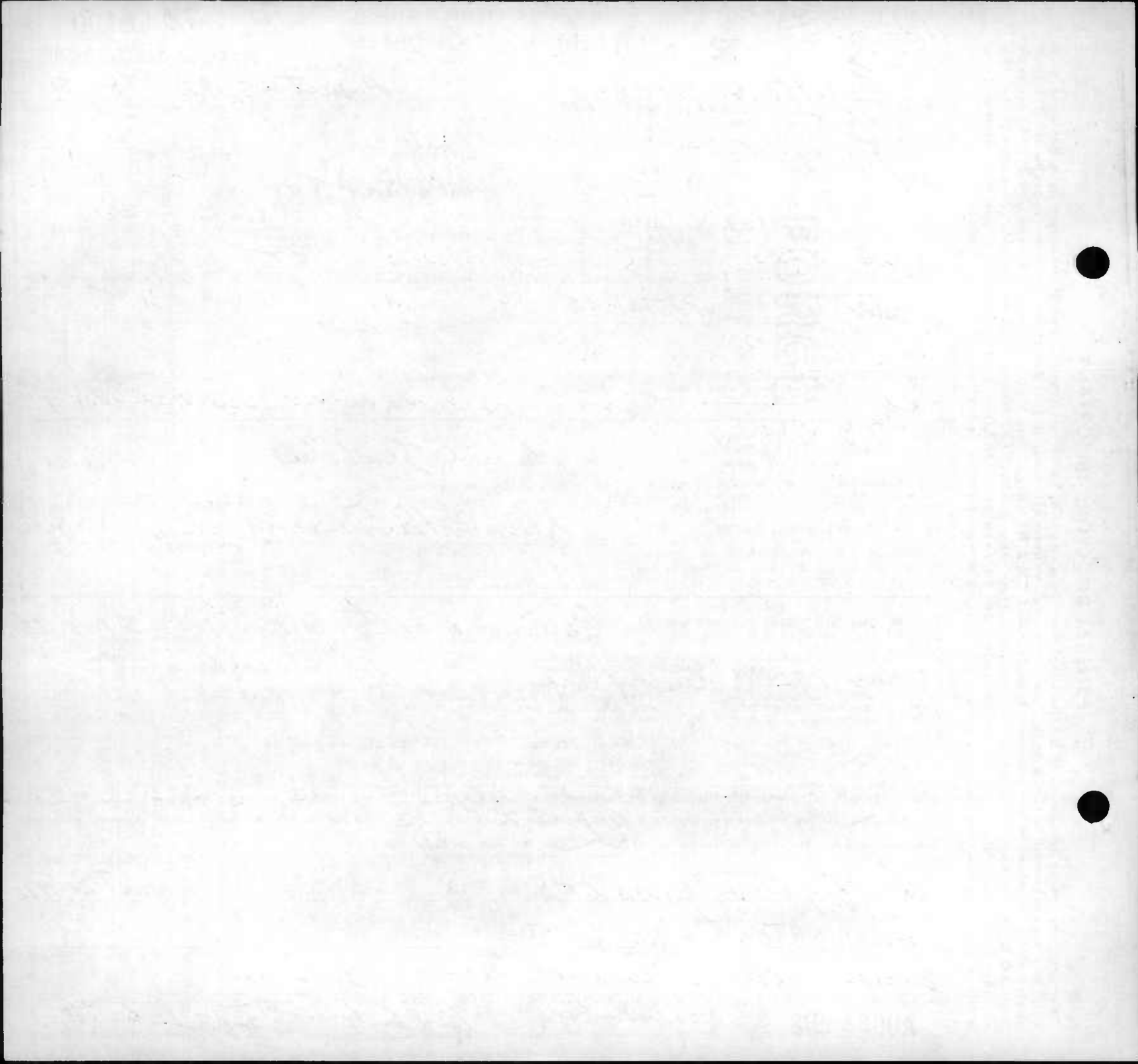
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08189	
S-500 72 08189				STATE OF MARYLAND-DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Maud Bernie Cary Snow		Aug. 22, 1972 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3838 Roland Avenue		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 2, 1878	9. AGE (In years last birthday) 93	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Albert Cary			14. MOTHER'S MAIDEN NAME Clara		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213 48 0680		
17. INFORMANT Edmund P. Dandridge Jr.			18. ADDRESS Trust Building Mercantile Bank &		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Atherosclerotic Heart Disease (A) IMMEDIATE CAUSE Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Heart Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 67 to 4-22 1972 that (I) (we) lost saw the deceased alive on 5-26 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Hunter Wilson, Jr.				23B. DATE SIGNED 8-24-72	
23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson, Jr. M.D.				23D. ADDRESS Medical Arts Building	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 25 Aug 72		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972			
25B. NAME OF REGISTRAR Sidney H. Wilson		25C. FUNERAL DIRECTOR Burgee Funeral Home By: Walter J. Henss			
25D. ADDRESS Baltimore, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08130</u>
M-500 <u>72 08130</u> CERTIFICATE OF DEATH				STATE OF MARYLAND - DEPT. OF HEALTH
1. NAME OF DECEASED (Type or Print) <u>Walter J. Mooney</u>		2. DATE AND HOUR OF DEATH <u>August 25, 1972</u> <u>8 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1207</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2919 MILES AVE 21211</u>		C. CITY OR TOWN <u>BALTO. CITY</u>
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2919 Miles Ave. 21211</u>		
5. SEX <u>MALE</u>	6. RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/13</u>	9. AGE (In years last birthday) <u>58</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>POTTS &amp; CALAHAN</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-01-3748</u>		17. INFORMANT <u>DONALD J. FRANCE</u>
				ADDRESS <u>1220 N. CALVERT ST.</u>
18. <u>398 X 1 + 141.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Pulmonary embolus</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Rheumatic Heart Disease with fibrillation</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>35 years</u> <u>5 months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Carcinoma of tongue</u>				
19A. DATE OF OPERATION <u>May 1972</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of tongue</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from <u>May 27</u> 19 <u>72</u> to <u>August 25</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>August 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>L. Myrton Gaines Jr. M.D.</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>August 26, 1972</u>
23C. PHYSICIAN'S NAME (Type) <u>L. MYRTON GAINES JR. M.D.</u>		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>8/28/72</u>	24C. NAME OF CEMETERY or CREMATORY <u>LORRAINE PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>		25B. NAME OF REGISTRAR <u>Audrey Whitton</u>		25C. FUNERAL DIRECTOR <u>Paul E. Demarest</u>
				ADDRESS <u>3617 Chestnut Ave.</u>



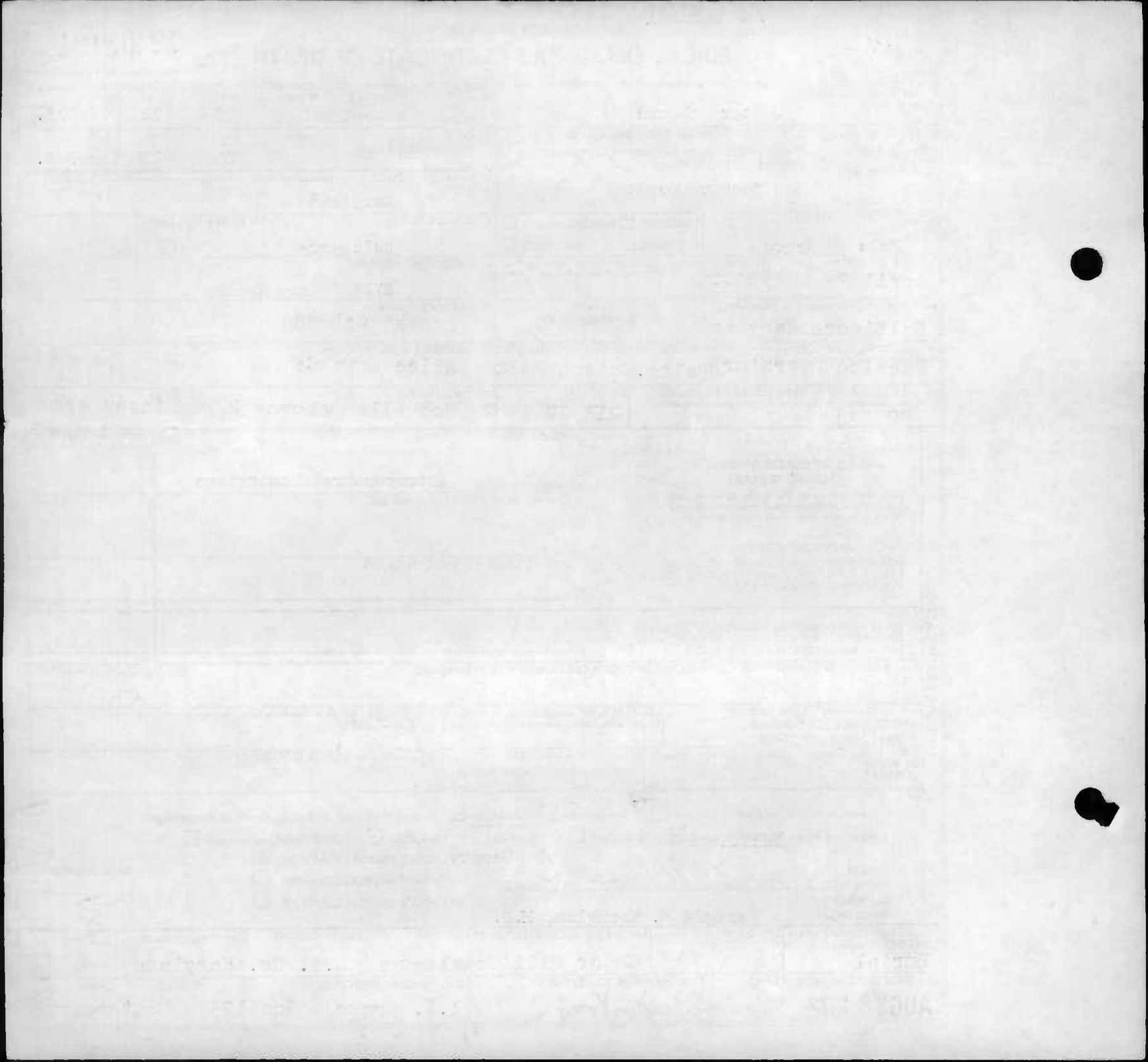
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08191

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Walter Osborne		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 25 72 11:03 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secour Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 25 72 11:03 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH April 24 1937		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years (last birthday)) 37		E. STREET AND NUMBER 2770 Kinsey Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF USA	
13. FATHER'S NAME Ernest Osborne		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator	
15. MOTHER'S MAIDEN NAME Alice Edwards		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 213 32 9482		18. INFORMANT Rochelle Osborne	
19. CAUSE OF DEATH 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Intracerebral hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 8-25-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8 29 72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR <i>Sidney Johnson</i>	
25C. FUNERAL DIRECTOR I.L. Brown & Son		25D. ADDRESS 123 W Montgomery	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08192

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HERMAN SILBER (Silver)</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 26, 1972 Hour 11:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year August 26, 1972 Hour 11:00 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2562</b>	
9. DATE OF BIRTH August 20 1930 42		10. AGE (In years lost birthday) If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Silver Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Clara Richardson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 217 26 3572		18. INFORMANT ADDRESS Esther Silver 2635 Round Road	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 732 S. Charles Street 2201		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8-26-72 9:40 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 27, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9 1 1972	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR Sidney Johnson	
25C. FUNERAL DIRECTOR I L Brown & Son 123 W. Montgomery		25D. ADDRESS	

WALL

Library

72 08193

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08193

BIRTH NO.

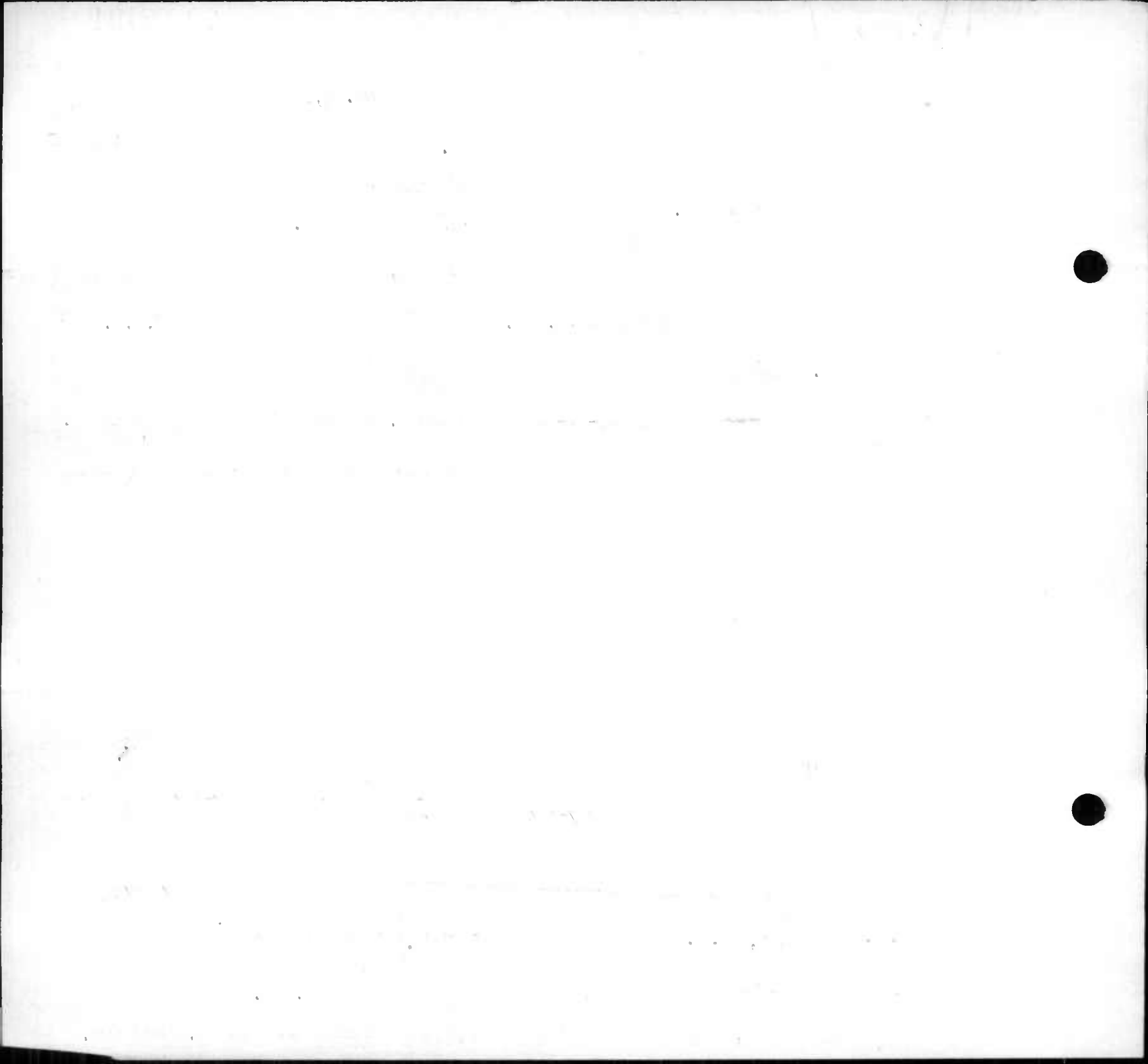
1. NAME OF DECEASED (Type or Print) <b>ARCHIE THOMAS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>8</b> Day <b>18</b> Year <b>72</b> Estimated <input type="checkbox"/> <b>8 18 72</b>		Hour <b>12:50 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>18</b> Year <b>72</b>		Hour <b>12:50 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>53-00</b>		C. CITY OR TOWN <b>Reisterstown</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>4343 Reisterstown</b>	
9. DATE OF BIRTH <b>July 5, 1913</b>		10. AGE (In years last birthday) <b>59</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		13. FATHER'S NAME <b>John W. Thomas</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Jane Denby</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
17. SOCIAL SECURITY NO. <b>220-05-5374</b>		18. INFORMANT ADDRESS <b>Mrs. Luhittie Pinder, East New Market, Md.</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Septicemia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Infection of left leg</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W P Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/19/72</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 22, 1972</b>	24C. NAME OF CEMETERY or CREMATORY <b>Thompsons town Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Near East New Market, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Whitson</b>		25C. FUNERAL DIRECTOR ADDRESS <b>From Hampton Jr. Frampton Funeral Home, Federalsburg, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-420		72 08194		BALTIMORE CITY HEALTH DEPARTMENT		72 08194	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Edward Joseph Gillece		Aug. 23, 1972		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
00 1307 Patapsco St.				Md.		2302	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		August 24, 1920	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Aberdeen Prove. Gns.		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas L. Gillece				Katherine Welch			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		4212-01-3673		Adele E. Gillece Wife 1307 Patapsco St.			
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
162.1 I		Carcinoma of the lung				1 year	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 70 to 8/14/ 1972 that (I) (we) last saw the deceased alive on 8/14/ 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
E.S. Ellison, M.D.				8/25/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		ADDRESS	
E.S. Ellison, M.D.		107 E. West Street		McGully Funeral Home 130 E. Fort Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-26-72		Holy Cross Cemetery		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 28 1972		[Signature]		McGully Funeral Home 130 E. Fort Ave.			

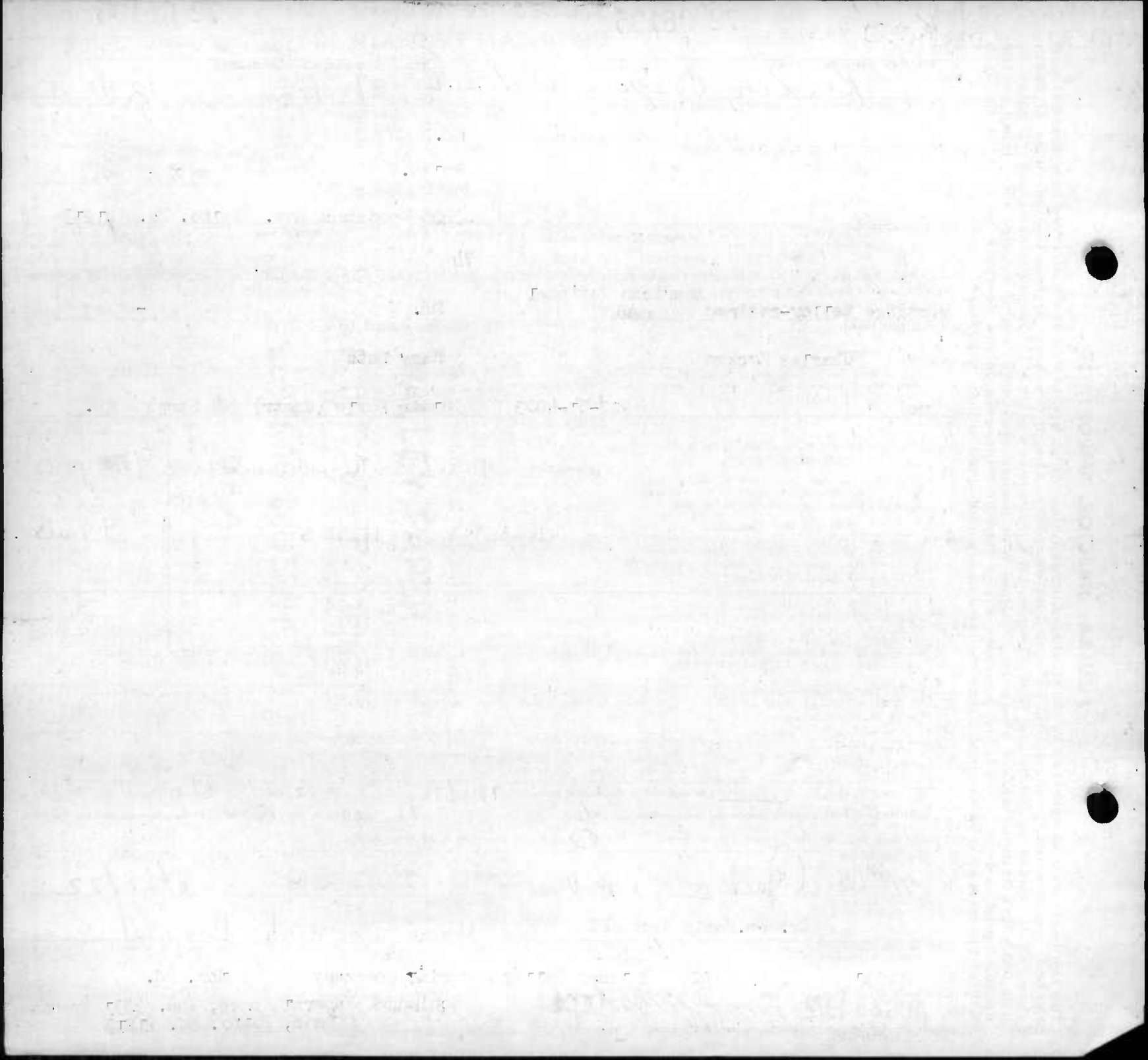


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 08195 BALTIMORE CITY HEALTH DEPARTMENT				72 08195		72 08195	
K-250				CERTIFICATE OF DEATH			
BIRTH NO.				REG. NO. <u>STATE OF MARYLAND-DHMH</u>			
1. NAME OF DECEASED (Type or Print) <u>Kecken Casper William Sr.</u>				2. DATE AND HOUR OF DEATH <u>8/22/72</u> <u>12:41 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND/WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital,</u> <u>4 Baltimore, Md.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>831</u>			
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>74</u> 9. AGE (In years last birthday) <u>77</u> 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mortgage teller-retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>American National Bank</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>-</u>			
13. FATHER'S NAME <u>Charles Kecken</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lutz</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-07-4203</u>			
17. INFORMANT <u>Clair Doyle (dghtr)</u>				ADDRESS <u>207 Margate Rd.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>250.91</u> <u>Arteriosclerotic cardiovascular disease</u> <u>9 years</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes mellitus</u> <u>9 years</u>							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/11/72</u> 19 <u>72</u> to <u>8/11</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>8/11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. Wm. David Jack III</u> M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/22/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Wm. David Jack III</u> DEGREE				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/24/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>		25B. NAME OF REGISTRAR <u>Andrew M. Woodford</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>		ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08196		72 08196	
H-200				72 08196		72 08196	
BIRTH NO.				72 08196		72 08196	
1. NAME OF DECEASED (Type or Print) <b>HOWES, LORENA</b>				2. DATE AND HOUR OF DEATH <b>AUGUST 26, 1972 2:15 A.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUES BALTIMORE, MARYLAND 21229</b>				C. CITY OR TOWN <b>ELLICOTT CITY</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>8696 DAVIS ROAD 21043</b>							
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07 17 85</b>		9. AGE (In years lost birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>CHARLES RIDGLEY</b>				14. MOTHER'S MAIDEN NAME <b>SARAH CATHERINE GOVER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>220-26-46088</b>		17. INFORMANT <b>BALTIMORE, MD. 21229</b> ADDRESS <b>ST AGNES RECORDS-WILKENS &amp; CATON AVES.</b>		
18. <b>440.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>on a chronic aortic valvular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>AUGUST 21, 1972</b> to <b>AUGUST 26, 1972</b> , that (1) (we) last saw the deceased alive on <b>AUGUST 26, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>08 26 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. ANTOINE FARHAT</b>				23D. ADDRESS <b>BALTIMORE, MD. 21229</b> <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVES</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-29-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MOUNTAIN VIEW CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>HOWARD COUNTY, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Disney Houston</b>		25C. FUNERAL DIRECTOR <b>HARRY H. WITZKE</b> <b>HOWARD COUNTY FUNERAL H.</b>		ADDRESS <b>ELLICOTT CITY, MARYLAND</b>	

62-7

CHIEF CLERK

NOV 22 1954

AUGUST 22 1954

RECEIVED

ELIZABETH CITY

ST. ANNE'S HOSPITAL  
1100 S. CALLE AVENUE  
BALTIMORE, MARYLAND 21205

2000 DAVIS ROAD

NOV 17 1954

RECEIVED

MARYLAND

CHARLES HIGGINS

ST. ANNE'S HOSPITAL

BALTIMORE, MD.

ST. ANNE'S HOSPITAL - BALTIMORE, MD.

AUGUST 21 1954

AUGUST 22 1954

XXXX

XXXX

BALTIMORE, MD.

ST. ANNE'S HOSPITAL

ST. ANNE'S HOSPITAL - BALTIMORE, MD.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">S-562</span> <span>72 08197</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>CITY HEALTH DEPARTMENT</span> <span>REG. NO. 72 08197</span> </div>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>72 08197</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>STATE OF MARYLAND</span> <span></span> </div>	
1. NAME OF DECEASED (Type or Print) <b>SELENA A. SOMERS</b>		2. DATE AND HOUR OF DEATH <b>Aug. 25, 1972. 8 AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2741</b>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>09-03-93</b>	
9. AGE (In years last birthday) <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>JOSEPH H. RIDER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH NORWOOD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-2761D</b>	
17. INFORMANT <b>Mr. Clifford P. Cole, Sr.</b>		ADDRESS <b>(Same)</b>	
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CEREBRO-VASCULAR Acc.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>08-03-1972</b> to <b>08-25-1972</b> , that (I) (we) last saw the deceased alive on <b>08-25-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>M. A. A. Latif M.D.</b>		23B. DATE SIGNED <b>08-25-1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. A. A. LATIF</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/28/72.</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS	

1945-1946

1947-1948

1949-1950

1951-1952

1953-1954

1955-1956

1957-1958

1959-1960

1961-1962

1963-1964

1965-1966

1967-1968

1969-1970

1971-1972

1973-1974

1975-1976

1977-1978

1979-1980

1981-1982

1983-1984

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08198</b>	
S-530 72 08198		CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND-DUMM	
1. NAME OF DECEASED (Type or Print) <b>MABEL R. SCHMIDT</b>		2. DATE AND HOUR OF DEATH <b>08/25/1972 09.45 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSPITAL.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BALTO.</b> B. COUNTY <b>2710</b>	
5. SEX <b>F</b>		6. RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/02/1896</b>	
9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone operator. - Hopkins Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Caleb PROUTY</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Auld</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-24-4936</b>	
17. INFORMANT <b>Allen E. Prouty Jr. mother</b>		ADDRESS <b>St</b>	
18. <b>531.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ACUTE G.I. BLEEDING + RENAL FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks 1 week</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PER GIDETRIC STRESS ULCER?</b>		DUE TO, OR AS A CONSEQUENCE OF: <b>1d.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ARTERIOSCLEROTIC CARDIOVASC. DISEASE</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>07/22/72</b> 19 to <b>08/25/72</b> 19, that (I) (we) last saw the deceased alive on <b>08/25/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>H. WENDORFF</b>		23B. DATE SIGNED <b>08/25/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>H. WENDORFF</b>		23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/28/72.</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney R. Ruck</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		ADDRESS	







**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 08139</span>	
72 08139				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">B-100</span>		STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) <span style="float: right;">Gregory Bopp</span>			2. DATE AND HOUR OF DEATH <span style="float: right;">August 25, 1972 1:00 A. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="float: right;">90 Edgewood Nursing Home</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">Maryland</span> B. COUNTY <span style="float: right;">2758</span>		
			C. CITY OR TOWN <span style="float: right;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="float: right;">1806 Ramblewood Ave</span>		
5. SEX <span style="float: right;">Male</span>	6. RACE <span style="float: right;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">Aug 25, 1904</span>	9. AGE (In years last birthday) <span style="float: right;">68</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Retired Clerk Acct</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Dept. B&amp;O C&amp;O RR</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>					
13. FATHER'S NAME <span style="float: right;">George Bopp</span>			14. MOTHER'S MAIDEN NAME <span style="float: right;">Margaret O'Connor</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">Yes WW 11</span>			16. SOCIAL SECURITY NO. <span style="float: right;">A705-05-3061</span>		17. INFORMANT <span style="float: right;">Mrs Lyda M Bopp</span>
			ADDRESS <span style="float: right;">Same</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">154.1 I</span>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">Ca of Rctum 6 mo.</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <span style="float: right;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">no</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">Feb.</span> 19 <span style="float: right;">72</span> to <span style="float: right;">Aug</span> 19 <span style="float: right;">72</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">22 Aug.</span> 19 <span style="float: right;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">Com. NKammer, Jr.</span>			23B. DATE SIGNED <span style="float: right;">8/25/72</span>		
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">For Dr. Frederick Volkmann</span>			23D. ADDRESS <span style="float: right;">6011 York Road</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">8/28/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">Holy Redeemer</span>	
24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore, Maryland</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">AUG 28 1972</span>		25B. NAME OF REGISTRAR <span style="float: right;">[Signature]</span>		25C. FUNERAL DIRECTOR <span style="float: right;">Leonard J. Ruck Inc. 5305 Harford Rd.</span>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08200

BIRTH NO.

REG. NO.

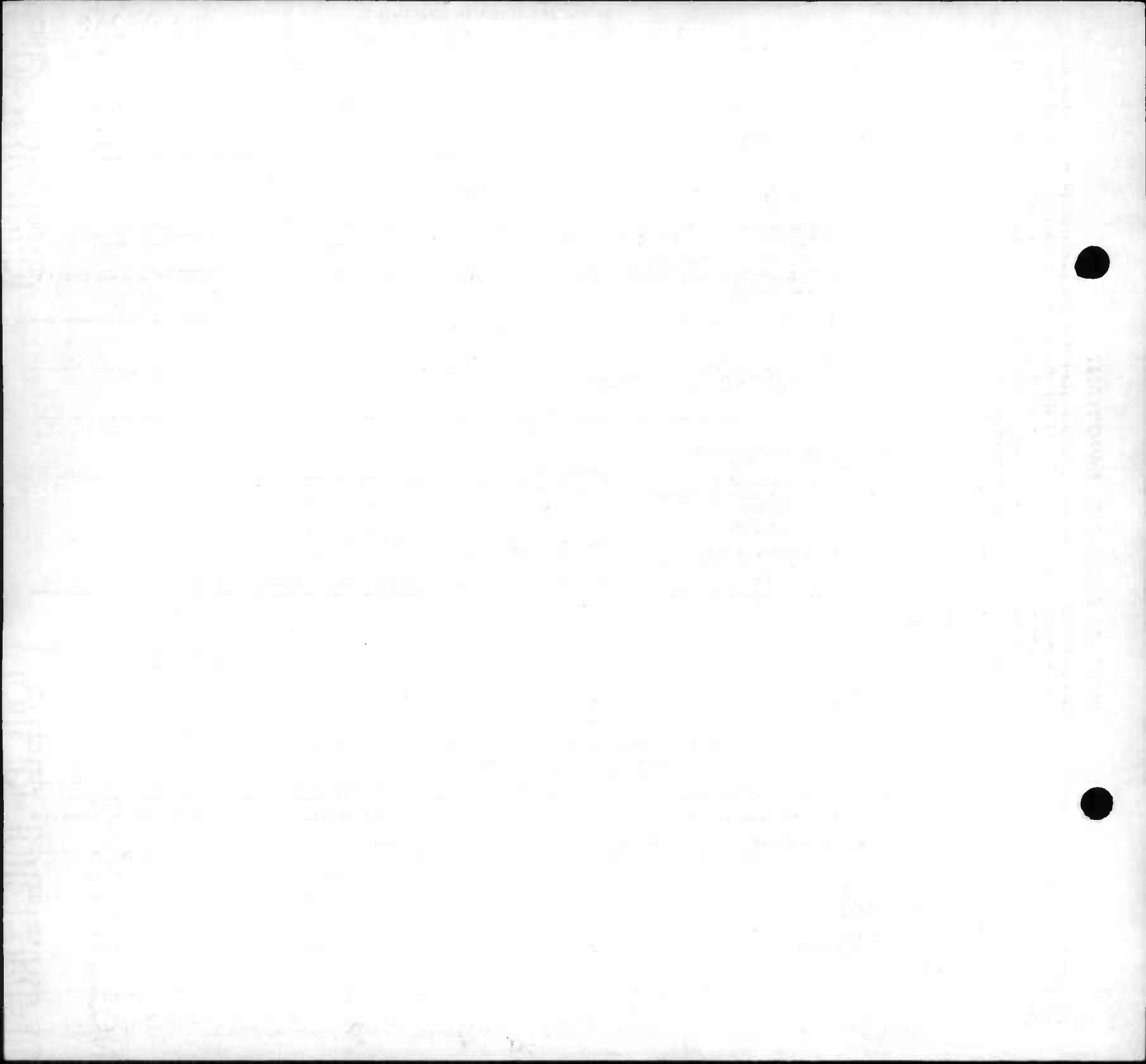
1. NAME OF DECEASED (Type or Print)		JOANN BARNES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour	
						August 25, 1972		2:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month Day Year		Hour	
Maryland General Hospital 423-73				August 25, 1972				2:55 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				A. STATE		B. COUNTY			
				Maryland		B. COUNTY		1702	
6. SEX	7. RACE	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
4/1/52		20		Baltimore, Md		What Country?			
14. USUAL OCCUPATION (Give kind of work done during last 12 months, if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
						Catherine			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
						Mrs Catherine Barnes, Same			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4221X				Acute Interstitial Myocarditis					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				Edema of brain					
				(B) Unidentified drug ingestion					
				DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)			
2						Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
		4		+					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
+		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		+					
23.									
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		ASSOCIATE MEDICAL EXAMINER	
Peter Lipkovic, M.D.				<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>	
								DATE SIGNED	
								August 26, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		8/30/72		MT Auburn Cemetry		Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
AUG 28 1972		Adolphus Halstead		Adolphus Halstead		1206 W North Ave			

1-23-1973 - Two (2) Letters from the Office of the Chief Medical Examiner,  
Peter Lipkovic, M.D., Assistant Medical Examiner.  
(1-dated 1-17-73 & 1-dated 1-22-1973) hs

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08201</b>	
A-536 72 08201				STATE OF MARYLAND-DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH		M.	
1. NAME OF DECEASED (Type or Print) <b>Anderson Daisy A.</b>		2. DATE AND HOUR OF DEATH <b>Aug 26, 72 19.45 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1510</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital Inc</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3500 Carsdale Ave</b>					
5. SEX <b>F</b>	6. RACE <b>B</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/00</b>	9. AGE (In years last birthday) <b>72</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>		11. BIRTHPLACE (State or foreign country) <b>Eastern Shore, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John Maxwell</b>		14. MOTHER'S MAIDEN NAME <b>Essie Jenkins</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-03-0942</b>		17. INFORMANT <b>Chester Anderson</b>	
ADDRESS <b>Same address</b>					
18. <b>39571</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Acute Cardiopulmonary Arrest</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>complete Heart block</b> (C) <b>Acute RENAL Failure &amp; cerebral embolism</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Aortic Stenosis &amp; insufficiency</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marcos B. Galicia Jr. M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>MARCOS B. GALICIA, Jr., M.D.</b>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/30/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Nat'l Mem. Park Balto., Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>MRS. Mary E. Law - 802 Madison Ave.</b>	



1		L-523		72 08202		STATE OF MARYLAND-DEPT BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 08202	
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) Wilson S. Le Master						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 8		Day 20	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home Hospital						3. DATE PRONOUNCED DEAD		Month 8		Day 20	
								Year 72		Hour 1:35 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						A. STATE Maryland		B. COUNTY 1207			
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH July 5, 1912			10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 2626 Miles Avenue		
13. FATHER'S NAME Harvey LeMaster						15. MOTHER'S MAIDEN NAME Mabel Donaldson					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman						14B. KIND OF BUSINESS OR INDUSTRY Automobile			18. INFORMANT Mrs. Mary Hedrick-Inwood, West, Virginia		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No						17. SOCIAL SECURITY NO. 234-01-9316			19. ADDRESS Route 1, Inwood, West, Virginia		
19. 412.41 CAUSE OF DEATH Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
20A. DATE OF OPERATION 0											
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED											
21. AUTOPSY? (Yes or No) No											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)						22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22F. HOW DID INJURY OCCUR?		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Russell S. Fisher</i> M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED 8-21-72											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Aug. 25, 1972		24C. NAME of CEMETERY or CREMATORY Pleasant View Memory Gardens				24D. LOCATION (City, town, or county) (State) Martinsburg, Berkeley, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972				25B. NAME OF REGISTRAR Sidney Whitson				25C. FUNERAL DIRECTOR Brown Funeral Home, Inc.			
								ADDRESS Martinsburg, W. Va.			



8-30-1972 - Letter from the Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner HRS

9-6-1972 - Letter from the Office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>R-320</b></span> <span><b>72 08203</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span></span> <span><b>72 08203</b></span> </div>	
BIRTH NO. <span style="float: right;"><b>STATE OF MARYLAND-DEATH</b></span>	
1. NAME OF DECEASED (Type or Print) <b>Ritchie Lee Anna</b>	
2. DATE AND HOUR OF DEATH <b>8/18/72 3:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bolton Hill Nursing &amp; E.C.F.</b> <b>90</b>	
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1601</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1231 W. Lafayette Ave</b>	
5. SEX <b>f</b>	6. RACE <b>Black</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-95</b>
9. AGE (in years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>213-54-1828</b>	
17. INFORMANT <b>Admission Record.</b> ADDRESS	
18. <b>412.4 14250.9</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema due to Heart Failure -</b> <b>A.S.C.V.D.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes Mellitus</b> <b>CVA - Left stroke</b>	
19A. DATE OF OPERATION	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (i) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (i) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Joseph S. Blum</b> DEGREE	
23B. DATE SIGNED <b>8/18/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH S. BLUM</b> DEGREE	
23D. ADDRESS <b>1115 N. GILBERT ST.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24B. DATE <b>8/22/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>MT. PLEASANT CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>DOWNS MILLS, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>	
25B. NAME OF REGISTRAR <b>Larry Horton</b>	
25C. FUNERAL DIRECTOR <b>Garland 1827 W. North Ave</b> ADDRESS	

SECRET

FUNERAL DIRECTOR: IMPORTANT

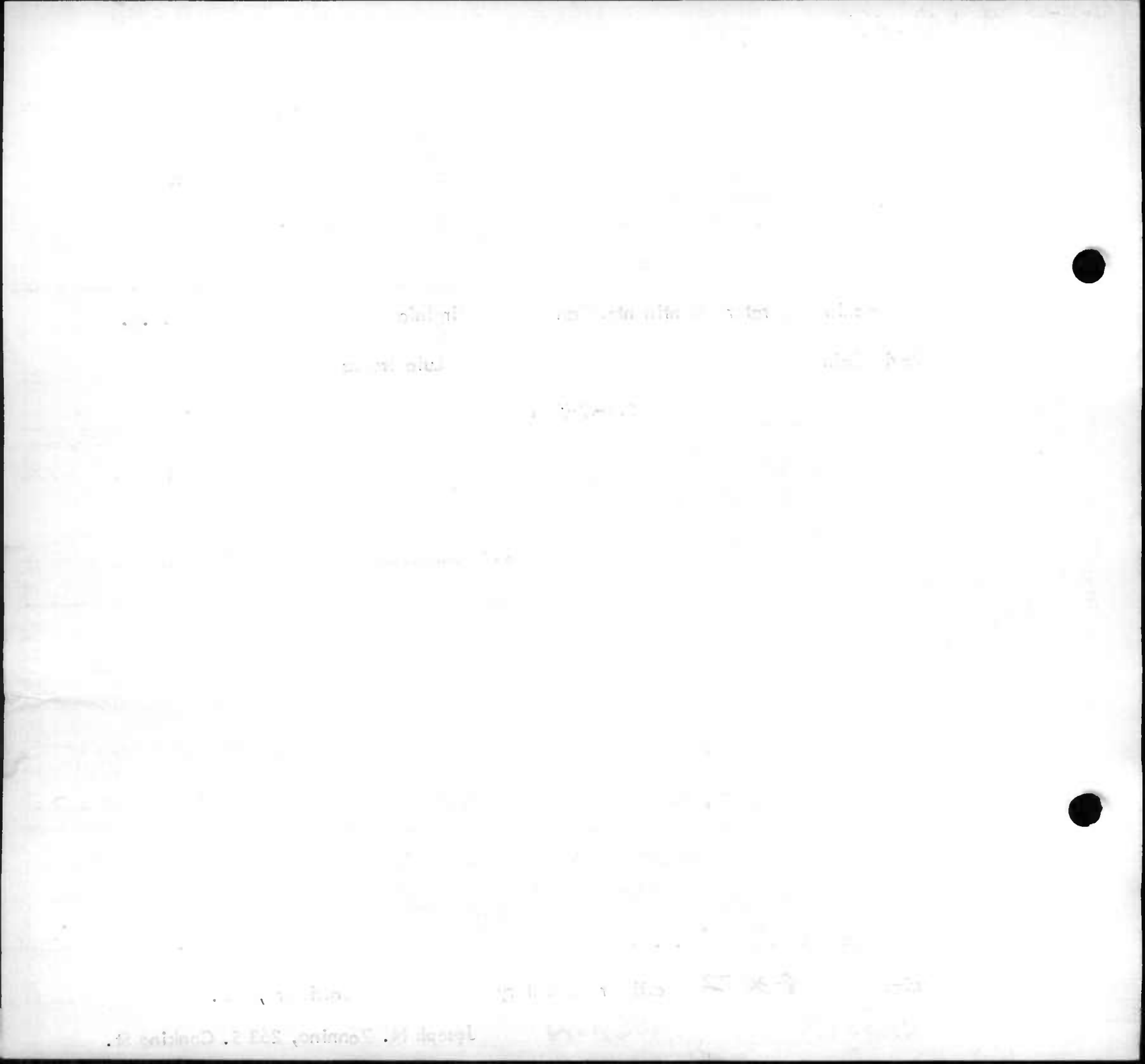
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620		72 08204		BALTIMORE CITY HEALTH DEPARTMENT		72 08204	
BIRTH NO.		72 08204		REG. NO.		72 08204	
1. NAME OF DECEASED (Type or Print) <u>Laura M. Grassi</u>				2. DATE AND HOUR OF DEATH <u>8/25/72</u> <u>10:45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF Maryland</u> <u>38 Hospital Baltimore, MD,</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12/29/17</u>		9. AGE (In years last birthday) <u>54</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Diego Marconi</u>				14. MOTHER'S MAIDEN NAME <u>Anna Campbell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>413-01-6172</u>		17. INFORMANT <u>Mr. W.M.A. Grassi-3907 E. Pratt St</u>	
18. <u>070X I</u> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		<u>Hepatic Failure</u> <u>5 days</u>	
ANTECEDENT CAUSES				(B) <u>Fulminant Hepatitis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>20 days</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>—</u>		<u>—</u>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>			
21D. TIME OF INJURY (Approx.) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>8/5</u> 19 <u>72</u> to <u>8/25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>Louis C. Kandel MD</u>				23B. DATE SIGNED <u>8/25/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Louis C. Kandel</u>	
23D. ADDRESS <u>Owings Mills, Md.</u>				23E. FUNERAL DIRECTOR <u>Zanino Funeral Home</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/28/72</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Stanislaus</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>		25B. NAME OF REGISTRAR <u>Lidney Whitton</u>		25C. FUNERAL DIRECTOR <u>Zanino Funeral Home</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530		72 08205		BALTIMORE CITY HEALTH DEPARTMENT		72 08205	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <i>Artie Bennett</i>				2. DATE AND HOUR OF DEATH <i>8/26/72 4:20 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>				A. STATE & COUNTY <i>Maryland 2608</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3413 Leverton Ave. 21224</i>			
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/12/07</i>	9. AGE (In years lost birthday) <i>65</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine Operator</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Continental Can</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>David Cain</i>				14. MOTHER'S MAIDEN NAME <i>Lula Brooks</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>218-10-7361</i>		17. INFORMANT ADDRESS <i>BCH Records 4940 Eastern Ave. 21224</i>		
18. <i>438.91</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>Sepsis - renal abscess, skull lesion</i> <i>48 hrs</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Severe arteriosclerotic disease</i> <i>years</i>			
				(C) <i>Central, peripheral vascular disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>2/13</i> 19 <i>72</i> to <i>8/26</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8/26</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Michael W. Pozen M.D.</i>				23B. DATE SIGNED <i>8/26/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Michael W. Pozen M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>8-30-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 28 1972</i>				25B. NAME OF REGISTRAR <i>Joseph N. Zennino</i>		25C. FUNERAL DIRECTOR ADDRESS <i>263 S. Conking St.</i>	

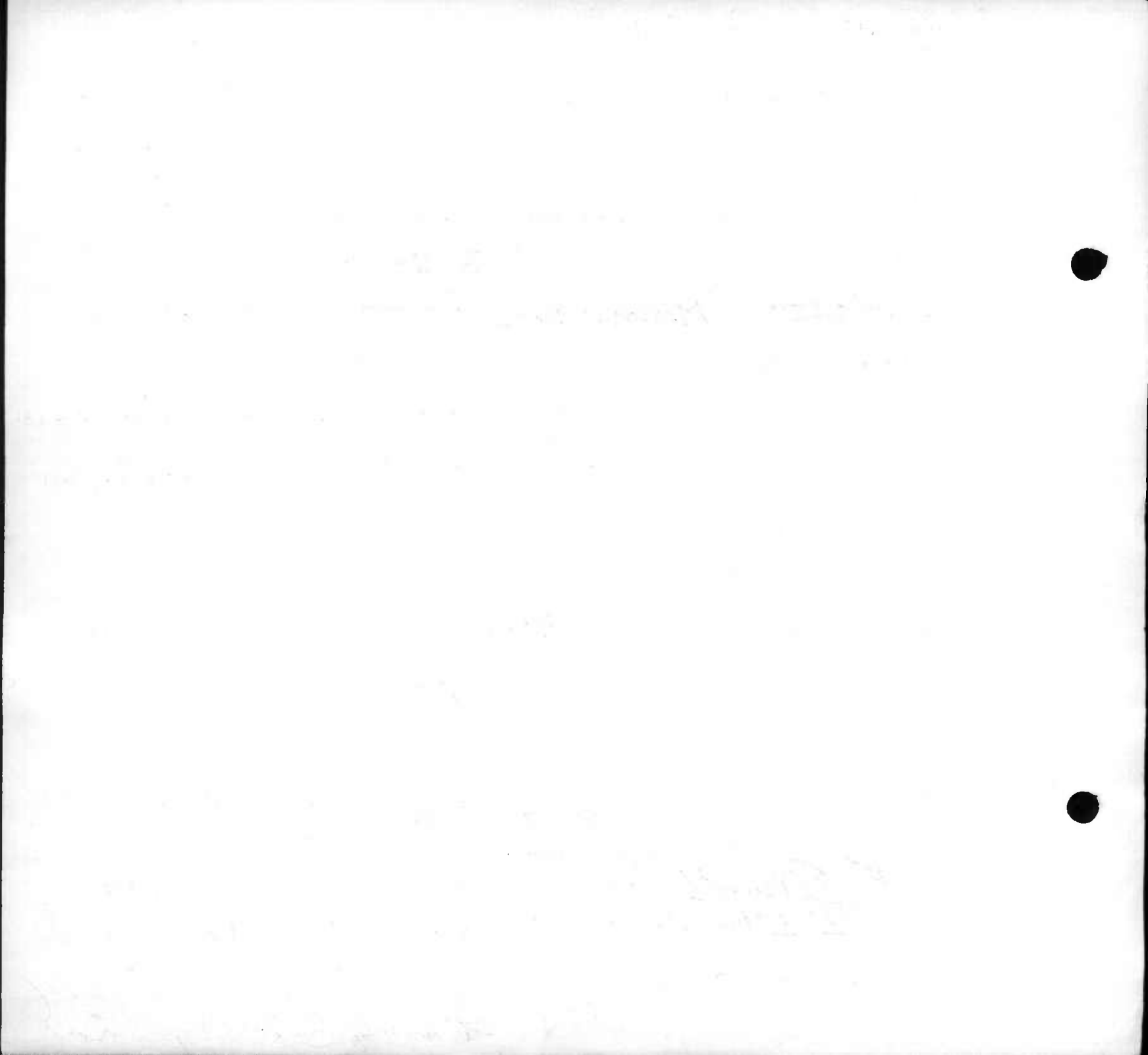




# FUNERAL DIRECTOR: IMPORTANT

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7-645		72 08206		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08206	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Frelund - Leo</u>				2. DATE AND HOUR OF DEATH <u>4:30 8-19-72</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1401</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MD. Gen. Hospital</u> <u>1101 Howard St. - Balto. Md</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>m</u>		6. RACE <u>C W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-1879</u> <u>93</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEA MAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT MARINE</u>		11. BIRTHPLACE (State or foreign country) <u>Finland RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>no</u>		16. SOCIAL SECURITY NO. <u>213-18-7225</u>		17. INFORMANT <u>Helen Sczytinski</u>		ADDRESS <u>TEL: 4-5821</u>	
18. <u>440191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Blind</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Several years</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Several years</u> (C) <u>Several years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Blind</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-17-1972</u> to <u>8-19-1972</u> that (I) (we) last saw the deceased alive on <u>8-17-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <u>E. Ellsworth Cook MD</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>8-19-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook MD</u>				23D. ADDRESS <u>2431 Maryland Ave. Balto. MD 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-21-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>O'Donnell St Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Hinton</u>		25C. FUNERAL DIRECTOR <u>Frederick Cook 7200 Harford Rd</u>			

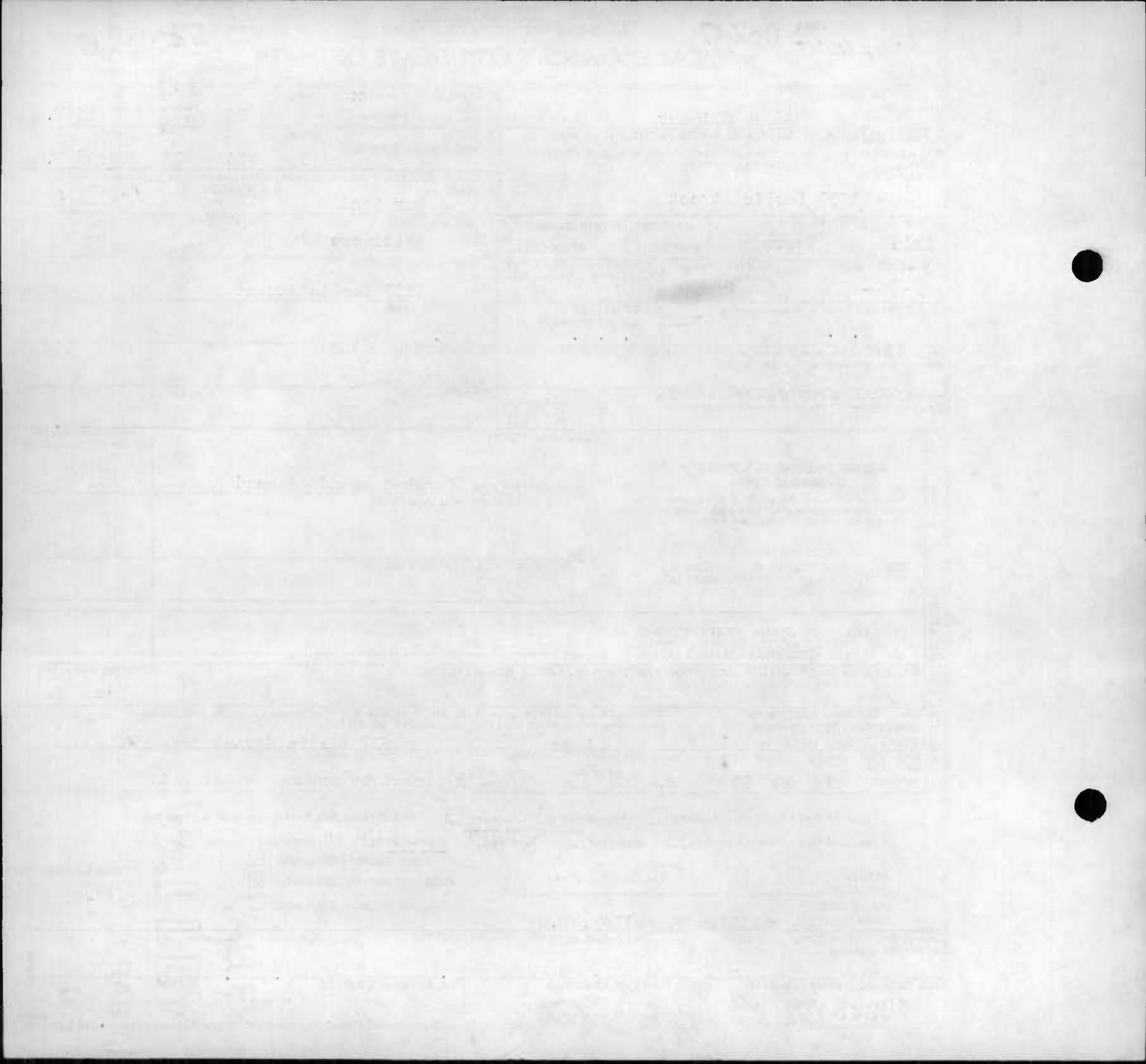


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jacob Skinner		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 24 72 9:15 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1537 Leslie Street		3. DATE PRONOUNCED DEAD Month Day Year 8 24 72 9:15 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1501	
9. DATE OF BIRTH 5-30-12		10. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		14B. KIND OF BUSINESS OR INDUSTRY RR	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 717090416	
18. INFORMANT Laura Peterson		ADDRESS 2109 Lynhurst Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME (Month) (Day) (Year) (Hour) 8 24 72 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1537 Leslie Street		22F. HOW DID INJURY OCCUR? shot by unknown assailants	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>W.P. Mulloy</i> M.D. EXAMINER'S NAME (Type) William P. Mulloy, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-28-72	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR <i>Sidney Johnston</i>	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun St.	



72 08208

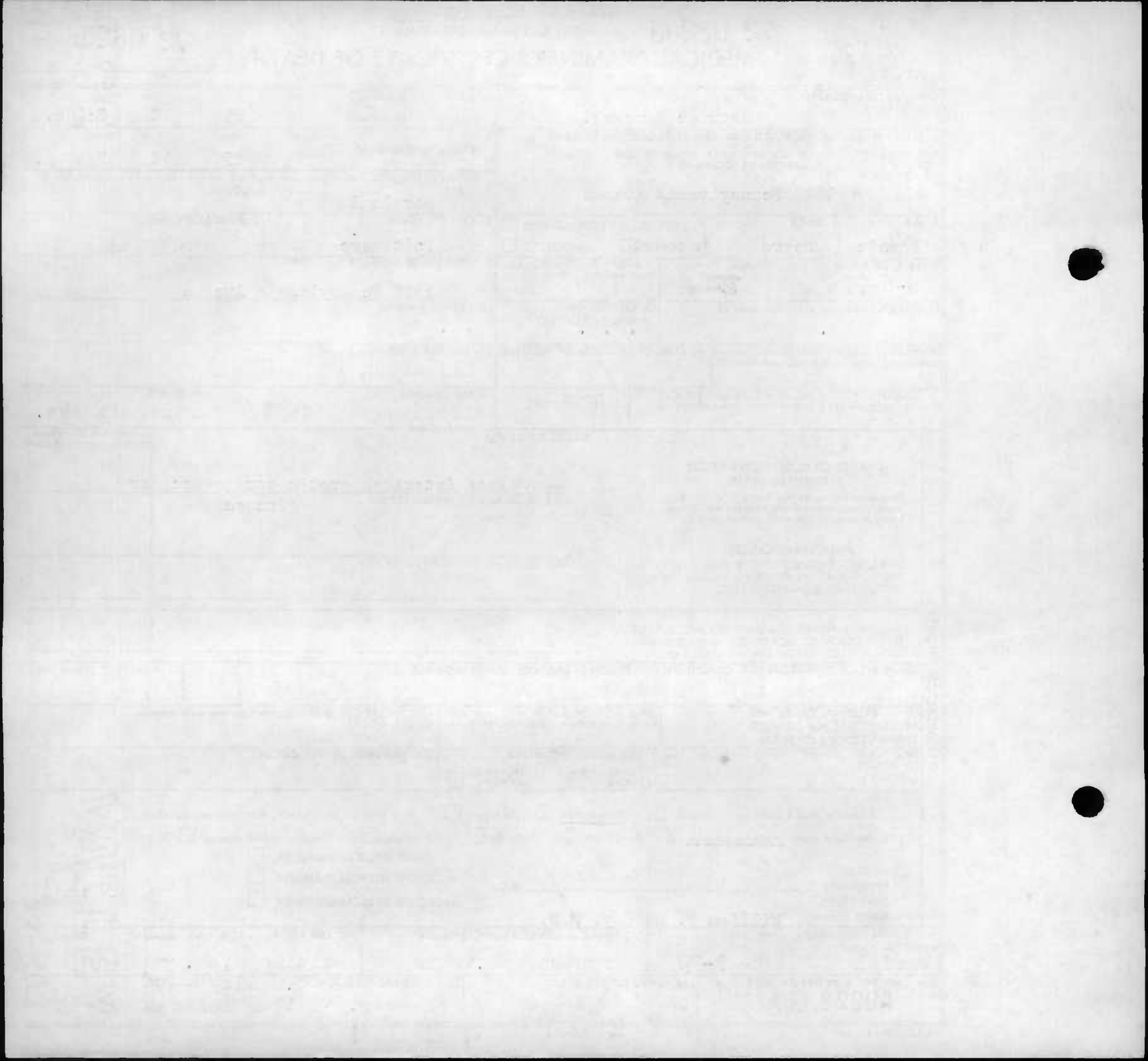
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08208

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Beatrice Marshall</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 25 72 7:40 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1928 Pennsylvania Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 25 72 7:40 A. M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6-6-97</b>		10. AGE (In years last birthday) <b>75</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Alice Queen</b>		ADDRESS <b>1928 Pennsylvania Ave.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W.P. Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8-25-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-29-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Anthony J. Horton</b>	
25C. FUNERAL DIRECTOR <b>V. Bailey</b>		ADDRESS <b>Kelson F.H. 1348 Calhoun Street</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-320		72 08209		Baltimore City Health Department		72 08209		REG. NO.		
BIRTH NO.		72 08209				STATE OF MARYLAND-DEATH				
1. NAME OF DECEASED (Type or Print) <b>HODGE, CHESTER</b>					2. DATE AND HOUR OF DEATH <b>August 26, 1972</b> <b>9:25 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1547</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd</b> <b>Baltimore, Maryland 21218</b>					C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>2105 Dukeland St</b>										
5. SEX <b>MALE</b>	6. RACE <b>NEGROID</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/18/16</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OILER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>BETH. STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>N/ North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>X USA</b>		
13. FATHER'S NAME <b>Phillip Hodge</b>					14. MOTHER'S MAIDEN NAME <b>Kate Rogers</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>			16. SOCIAL SECURITY <b>3812 217 26 1872</b>		17. INFORMANT <b>Catherine Hodge</b> <b>CLIN RCDS, VAH, BALTIMORE, MARYLAND</b>			ADDRESS <b>same 21218</b>		
18. CAUSE OF DEATH <b>5-17-72</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE RESPIRATORY FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>5 yrs</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										
19A. DATE OF OPERATION <b>NONE</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 12, 1972</b> to <b>August 26, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 26, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <del>not</del> view the body after death.										
23A. SIGNATURE <i>Ronald E. Klug</i>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>8/26/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>DONALD KLUG, M.D.</b>					23D. ADDRESS <b>VA HOSPITAL, BALTIMORE, MARYLAND 21218</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>8-30-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>			24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>			25B. NAME OF REGISTRAR <i>Sidney S. Houston</i>			25C. FUNERAL DIRECTOR <b>George Kelson</b>			ADDRESS <b>1348 N Calhoun BALTO, MD.</b>	



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**FUNERAL DIRECTOR: IMPORTANT**

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G-520		72 08210		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08210	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND-DEM	
1. NAME OF DECEASED (Type or Print) <b>HAROLD GAINES</b>				2. DATE AND HOUR OF DEATH <b>8/19/72</b> <b>7 10 P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UN. V. OF MARYLAND HOSPITAL</b>				A. STATE <b>MD</b>		B. COUNTY <b>BALTIMORE</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALT.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>38</b>				E. STREET AND NUMBER <b>MONTEBELLO STATE HOSPITAL</b>			
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/14/43</b>	9. AGE (In years last birthday) <b>29</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GA.</b>	
13. FATHER'S NAME <b>GEORGE GAINES</b>				14. MOTHER'S MAIDEN NAME <b>ULA SADLER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-40-8851</b>		17. INFORMANT <b>Geo. Gaines</b>	
				ADDRESS <b>2908 Reisterstown Rd.</b>			
18. <b>038.91</b>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>CARDIAC + RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>SEPSIS (gm - + gm +)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>48 hours</b>			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>PARAPLEGIA -</b>							
19A. DATE OF OPERATION <b>6/27/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SMALL BOWEL F-STULA</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>4/12</b> 19 <b>72</b> to <b>8/19</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>8/19</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Re Lore MD</b>				23B. DATE SIGNED <b>8/19/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Re Lore MD</b>	
23D. ADDRESS <b>BALTO. CEM.</b>				23E. FUNERAL DIRECTOR <b>U. BAILEY</b> ADDRESS <b>1348 Calhoun St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE ISSUED BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Raymond L. ...</b>		25C. FUNERAL DIRECTOR <b>U. BAILEY</b> ADDRESS <b>1348 Calhoun St.</b>			

5/5/71

513 Glenwood 21212

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

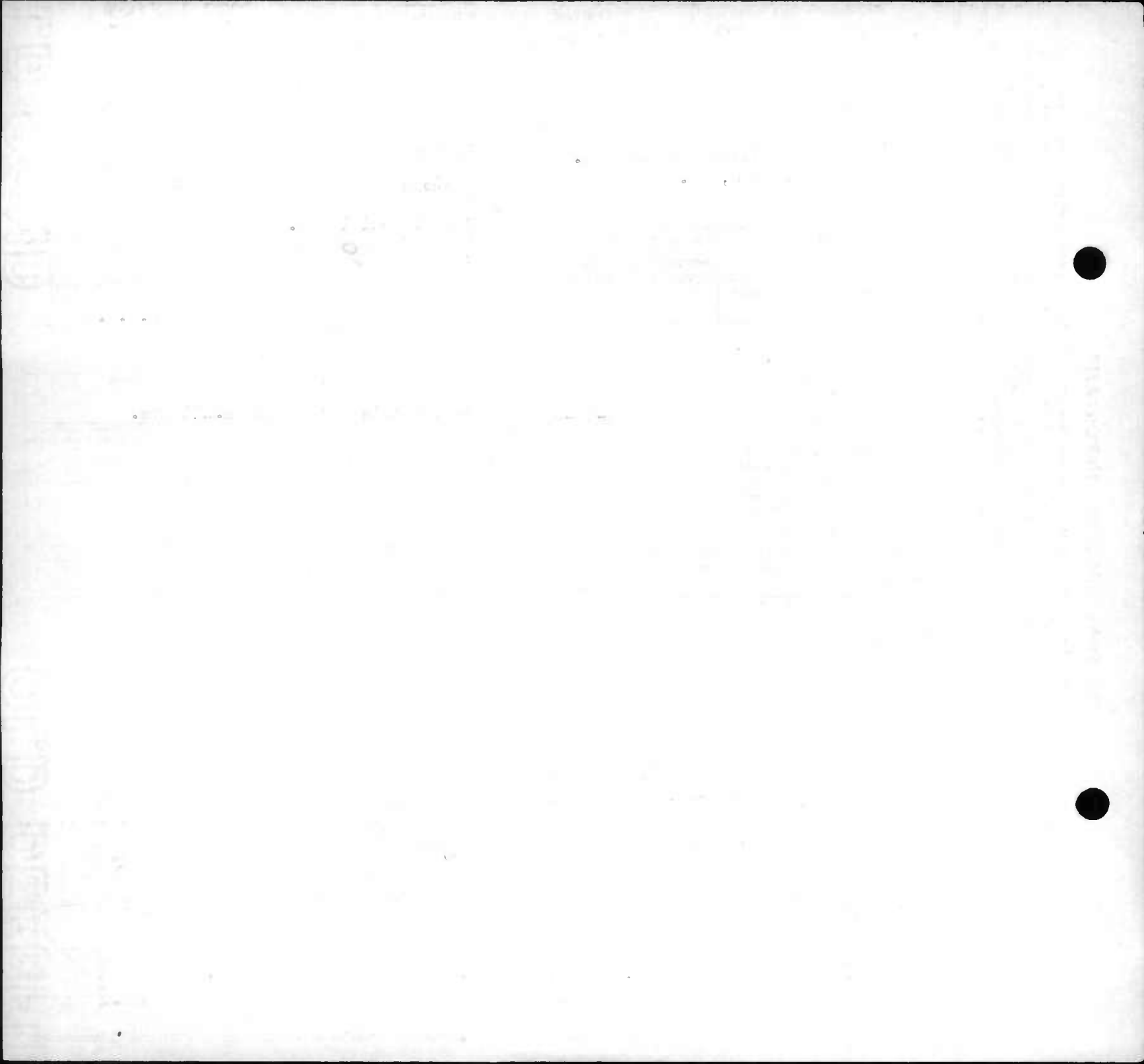
BALTIMORE CITY HEALTH DEPARTMENT				72 08211		REG. NO.	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHNNIE DUKES</b>				2. DATE AND HOUR OF DEATH <b>AUG. 23/72 10:35AM.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1605</b>			
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-15-96</b>	
9. AGE (In years last birthday) <b>76</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LAWRENCE DURANT</b>				14. MOTHER'S MAIDEN NAME <b>JANIS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. ADDRESS <b>Sidney Dukes - 906 Warwick</b>	
18. <b>436.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIORESPIRATORY ARREST</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CVA</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>CVA</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8-26-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7-19</b> 19 <b>72</b> to <b>8-23</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8-23</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Manning md</b>				23B. DATE SIGNED <b>8-23-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>RUBEN MANRIQUEZ MD</b>				23D. ADDRESS <b>LUTHERAN HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-26-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Wharton</b>		25C. FUNERAL DIRECTOR <b>Kelson F. H. Bailey</b>		ADDRESS <b>7548 Calhoun St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

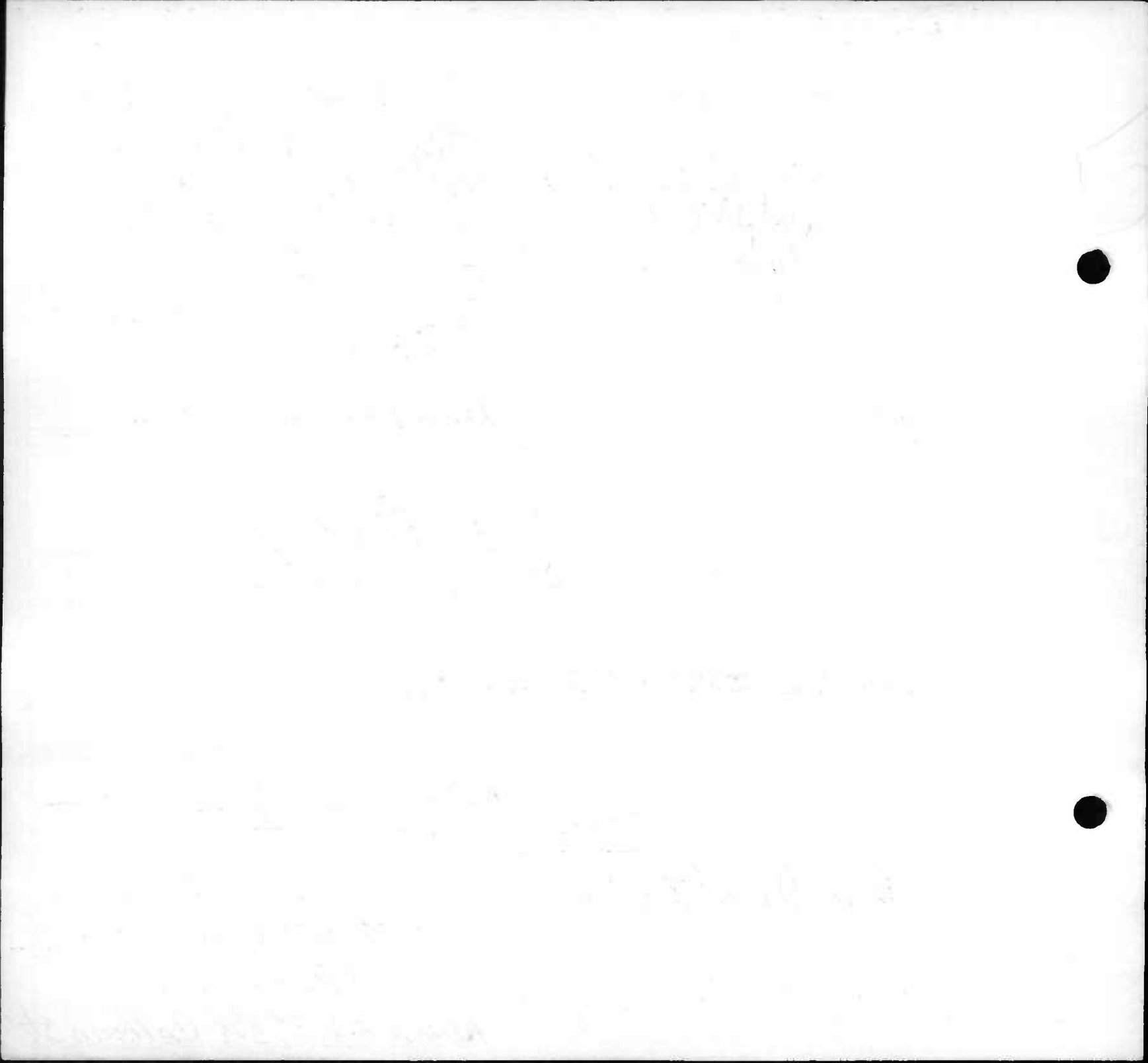
BALTIMORE CITY HEALTH DEPARTMENT				72 08212		72 08212	
H-314				72 08212		72 08212	
BIRTH NO.				72 08212		72 08212	
1. NAME OF DECEASED (Type or Print) <i>Hatfield McKusley</i>				2. DATE AND HOUR OF DEATH <i>Aug. 25, 72 1:45 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>39 Provident Hosp</i>				A. STATE <i>Maryland</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS) <i>2000 Liberty Height Ave. Baltimore, Md. 21215</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>				6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>10/15/98</i>	
13. FATHER'S NAME <i>Geo. Hatfield</i>				14. MOTHER'S MAIDEN NAME <i>Nettie Smith</i>		9. AGE (In years last birthday) <i>72</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>218-40-4595</i>		11. BIRTH (PLACE (State or foreign country) <i>Alabama</i>	
17. INFORMANT <i>Robert Hatfield</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Bronchogenic carcinoma with metastases</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-18-72</i> to <i>8-25-72</i> that (I) (we) last saw the deceased alive on <i>8/25</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>V. Chitraplee</i>				23B. DATE SIGNED <i>8/25/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>V. Chitraplee</i>				23D. ADDRESS <i>Provident Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-28-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 28 1972</i>				25B. NAME OF ASSISTANT <i>Wilson R. Bailey</i>			
25C. FUNERAL DIRECTOR <i>Wilson R. Bailey</i>				ADDRESS <i>1348 Calhoun St.</i>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08213		REG. NO. 72 08213	
E-163				72 08213		STATE OF MARYLAND-DHMH	
BIRTH NO.				72 08213		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JESSIE MAE EVERETT</b>				2. DATE AND HOUR OF DEATH <b>8-26-72 11:45 p.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>				A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
38				E. STREET AND NUMBER <b>1641 Babelway Court 1502</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-17</b>		9. AGE (In years last birthday) <b>55 yrs</b>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>Lula Mark</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Leona Plummer - Same</b>		ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>				(A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: <b>Pulmonary Edema</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO OR AS A CONSEQUENCE OF: <b>Carcinomatosis</b>			
				(C) <b>Carcinoma Cervix</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>7-7-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal Obstruction</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7-7-72</b> to <b>8-26-72</b> that (I) (we) last saw the deceased alive on <b>8-26</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B. L. Hamilton M.D.</b>				23B. DATE SIGNED <b>8-26-72</b>		23C. PHYSICIAN'S NAME (Type) <b>University of Maryland Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8-30-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Dr. Reuben</b>	
24D. LOCATION <b>Balto., Md.</b>				24E. NAME OF REGISTRAR <b>Aug 28 1972</b>		24F. FUNERAL DIRECTOR <b>A. B. Bailey</b>	
24G. ADDRESS <b>1348 Calhoun St.</b>				24H. NAME OF REGISTRAR <b>Aug 28 1972</b>		24I. FUNERAL DIRECTOR <b>A. B. Bailey</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08214		72 08214	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DEHM	
1. NAME OF DECEASED (Type or Print) <b>KOUNESKI DOMINICK</b>				2. DATE AND HOUR OF DEATH <b>8-25-92</b>		7. 10 A.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE BELVEDERE AT GREENSPRING BAL. MD</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>203</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>♂</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>7-26-08</b> 9. AGE (In years last birthday) <b>64</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WALLMOUTH</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>DOMINIC KOUNESKI</b>	
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W. II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARY KOUNESKI</b>				ADDRESS <b>3612 COURTLEY DR.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>RECURRENT VENTRICULAR FIBRILLATION</b>			
				(B) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <b>TRACHEAL STENOSIS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8-22-92</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TRACHEAL STENOSIS</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?				22. I certify that (I) (this hospital) attended the deceased from <b>8-18-92</b> to <b>8-25-92</b>		that (I) (we) last saw the deceased alive on <b>8-25-92</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Narong Sirisabya, M.D.</b>				23B. DATE SIGNED <b>8-25-92</b>		23C. PHYSICIAN'S NAME (Type) <b>NARONG SIRISABYA</b>	
23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE BELVEDERE AVE AT GREENSPRING BAL. MD</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-29-92</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>				24D. LOCATION (City, town, or county) <b>Dundalk</b>		(State) <b>MD</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 28 1992</b>				25B. NAME OF REGISTRAR <b>Indy W. Houston</b>		25C. FUNERAL DIRECTOR <b>John M. W. &amp; Sons, Inc.</b>	
				ADDRESS <b>401 S. Chestnut St.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 08215</span>	
72 08215 CERTIFICATE OF DEATH					
BIRTH NO.		STATE OF MARYLAND-DEMC			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mabel S. Weibe		8-26-72		8:05 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland			
90 Gould Nursing Home		C. CITY OR TOWN Lutherville		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 1207 York Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Mar. 23, 1885	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		at home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John William Taylor		Eva Mary Strauss			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		219 58 5920		Mrs Edna V. Spellman 2715 North Charles	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Antisclerotic Heart Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Generalized Atherosclerosis			
		(C) ...			
II		B-K Respiratory Septic secondary to peripheral vascular disease - 3 days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/16/72 to 8/26/72, that (I) (we) last saw the deceased alive on 8/24/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Albert B. Bradley				8/26/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Albert B. Bradley, M.D.				4900 Belair Road 21206	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/29/72		Loudon Park Cemetery	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 28 1972		Sidney B. ...		Henry Sander & Sons Inc. Baltimore Maryland 21213	

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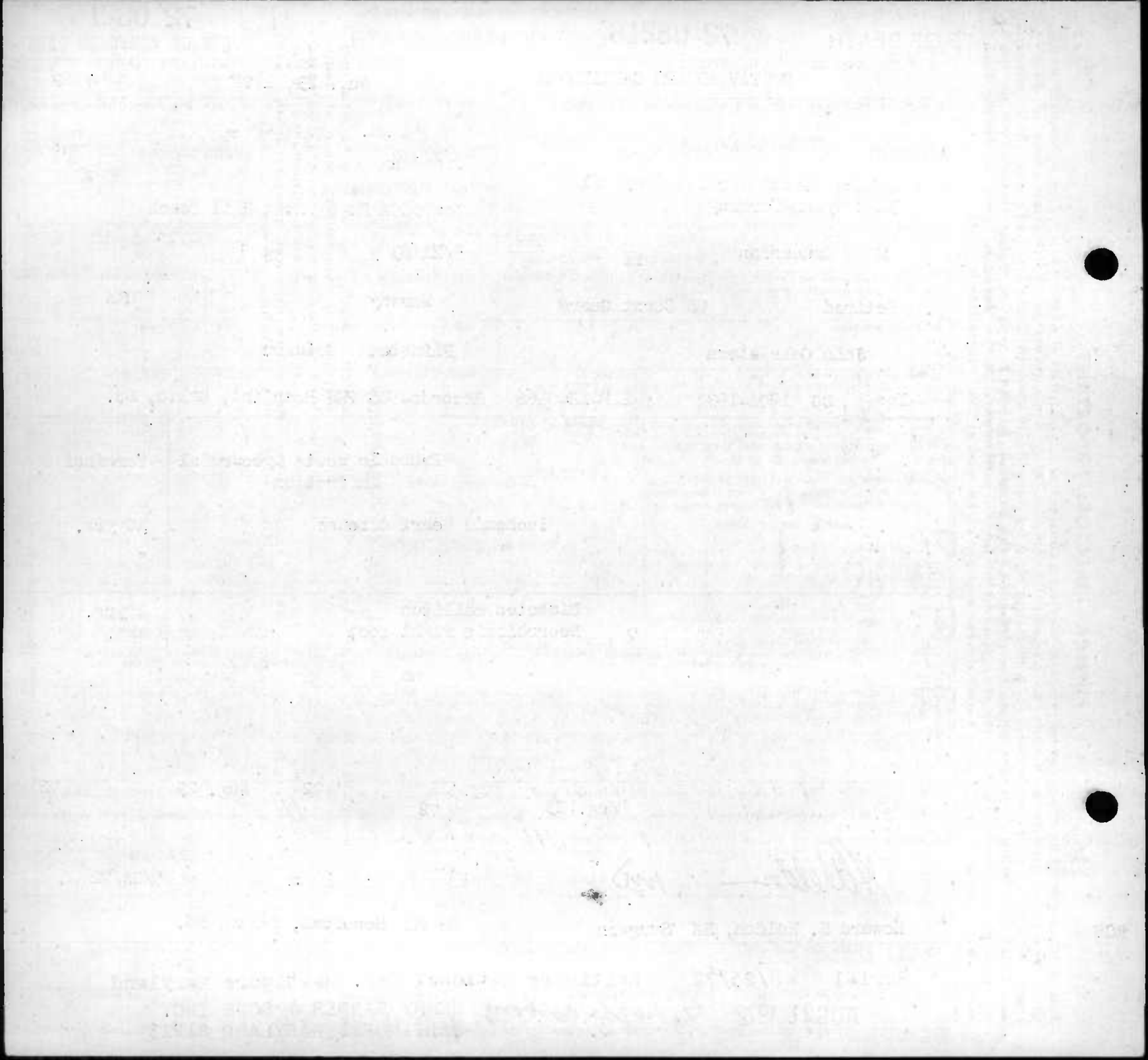
1955

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08216
72 08216 CERTIFICATE OF DEATH				REG. NO. 72 08216
BIRTH NO.		STATE OF MARYLAND-DEME		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
GUSTAV ADOLPH GABRIELSEN		Aug. 23, 1972		7 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  US Public Health Service Hospital 3100 Wyman Parkway		A. STATE Md. B. COUNTY AA C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER Box 509A Rt 6 Rock Hill Beach				
5. SEX M	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/83	9. AGE (In years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY US Coast Guard		11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME John Gabrielsen		14. MOTHER'S MAIDEN NAME Elizabeth Golaxon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes CG 1905-1938		16. SOCIAL SECURITY NO. 218-18-0166		17. INFORMANT Records- US PHS Hospital, Balto, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  410.91-250.9 Probable acute myocardial infarction Terminal		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: infarction		
		(B) Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF: 10 yrs.		
		(C) Diabetes mellitus Necrobiosis right foot 2 yrs. 3 wks.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Aug. 11 1972 to Aug. 23 1972, that (I) (we) last saw the deceased alive on Aug. 23 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>H. Weldon</i> MD.		23B. DATE SIGNED 8/24/72		
23C. PHYSICIAN'S NAME (Type) Howard S. Weldon, SA Surgeon		23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/25/72		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. Baltimore Maryland
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR <i>Andrew H. Hoston</i>		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE, MARYLAND 21213





# FUNERAL DIRECTOR: IMPORTANT

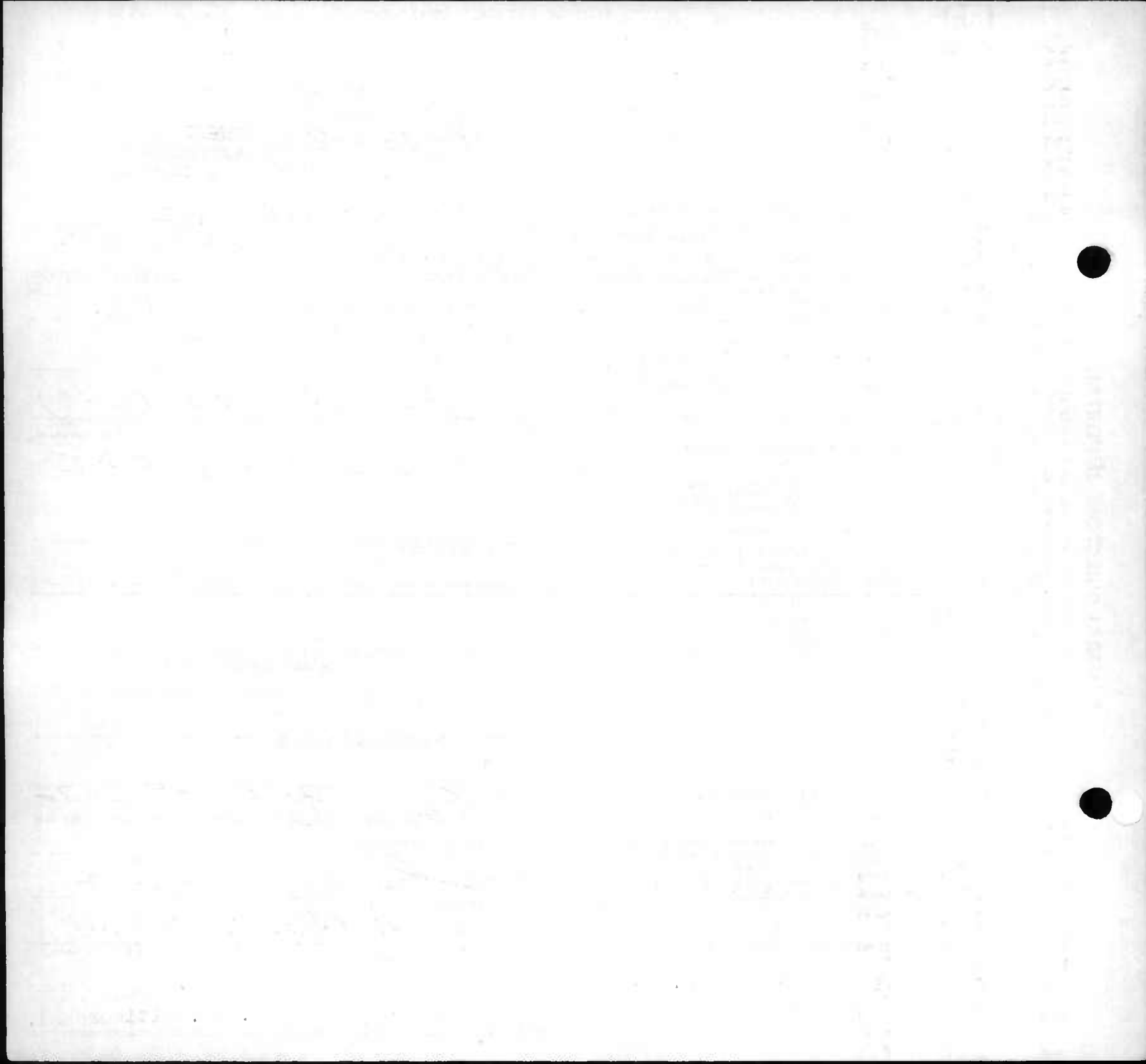
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 08217

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 72 08217  
STATE OF MARYLAND-DEME

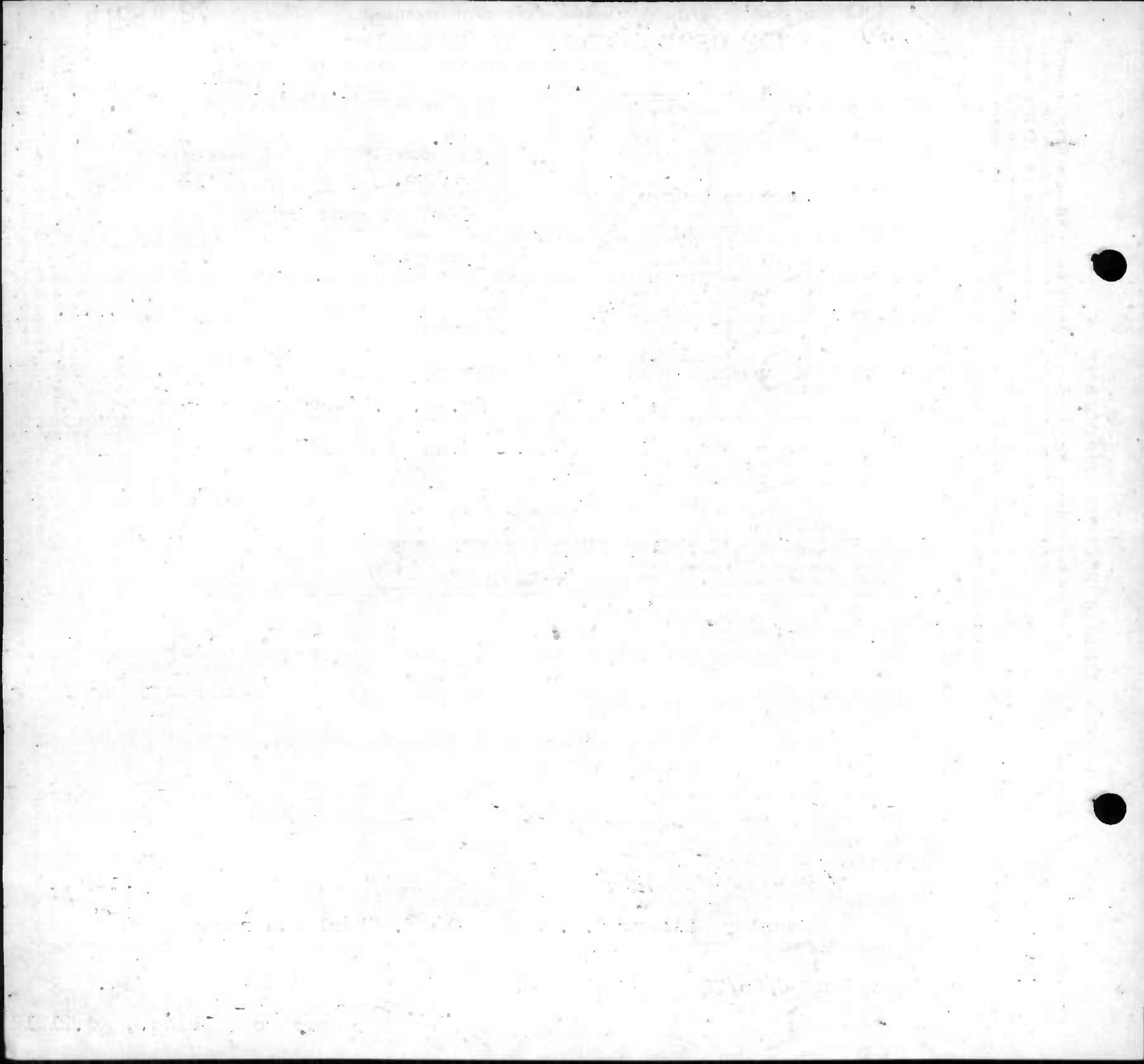
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BRADBURN JAMES W</b>		2. DATE AND HOUR OF DEATH <b>AUG 24 1972 5<sup>45</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE 21218</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>04-15-97</b>		9. AGE (In years last birthday) <b>75</b>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ACCOUNTANT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOSEPH Bradburn</b>		14. MOTHER'S MAIDEN NAME <b>AGNESS GOTT</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-3859</b>		17. INFORMANT ADDRESS <b>ETHEL M. BRADBURN (WIFE)</b>	
18. <b>433,191</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>CEREBRAL THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (his hospital) attended the deceased from <b>8-18</b> 19 <b>72</b> to <b>8-24</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8-23</b> - 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Francis X. Carmody</b> DEGREE				23B. DATE SIGNED <b>8-24-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANCIS X. CARMODY</b> DEGREE				23D. ADDRESS <b>3201 N. CHARLES BALT, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitlock</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HENRY SANDER &amp; SONS, INC. Baltimore Md.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

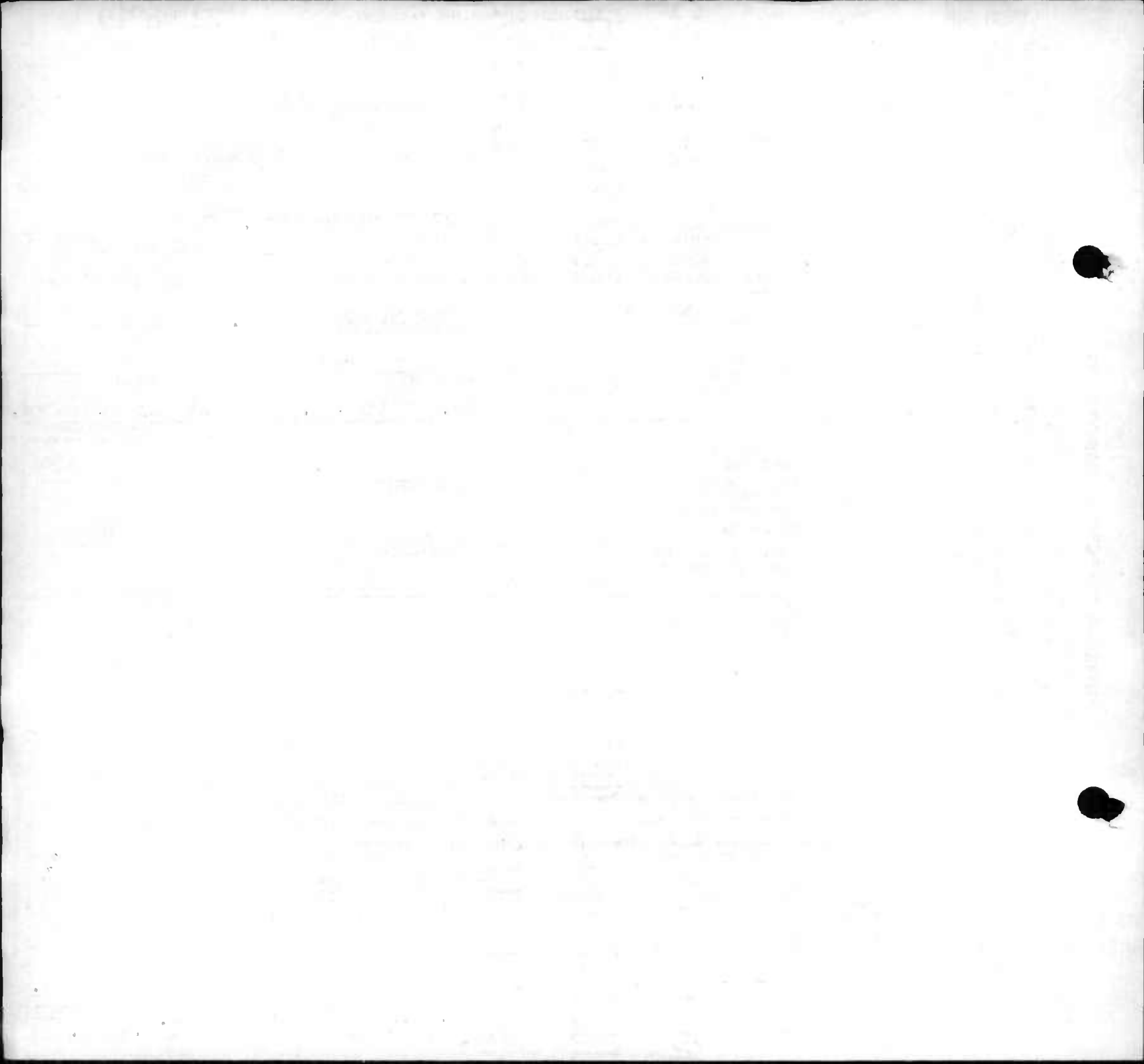
BALTIMORE CITY HEALTH DEPARTMENT				72 08218		72 08218	
K-450				72 08218		72 08218	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND - <del>DEPT.</del>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Miss Wanda Anna Klein				Aug. 25, 1972   2:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 1007 Argonne Drive				Md. 902			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1007 Argonne Drive			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/21/1892	80			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker				New York		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Klein				Carder			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Mr. R. C. Garrison (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Congestive heart failure			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Hypertension, atherosclerosis			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Antecedent CVI			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 21, 1972 to Aug 25, 1972, that (I) (we) last saw the deceased alive on Aug 18, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Stanley Miller, M.D.				2/5/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Stanley Miller, M.D.				914 N. Charles Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		8/26/72		Loudon Park		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
AUG 28 1972		H. W. Jenkins & Sons Co.		424905 York Road Balto., Md.		21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08219		72 08219	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>Mabel A. Kinzie</b>		2. DATE AND HOUR OF DEATH <b>8-25-72 11:45 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2702</b>			
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-11-96</b>	
9. AGE (in years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Howard County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Woodward</b>				14. MOTHER'S MAIDEN NAME <b>Grace Poist</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 07 8786</b>		17. INFORMANT ADDRESS <b>Mr. William K. Cogswell 513 Park Ave.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>3-77-01</b> <b>HEMORRHAGIC PANCREATITIS</b> <b>UREMIA</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~4 days</b>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>PENDING</b> <b>YES - (SIGNATURE OF TRUSTEE IN AM)</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>8-25-72</b> to <b>8-25</b> 19 <b>72</b>		that (1) (we) last saw the deceased alive on <b>8-25</b> 19 <b>72</b> and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W H Bouchelle MD</b>				23B. DATE SIGNED <b>8-25-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>William H Bouchelle MD</b>				23D. ADDRESS <b>Md. Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-29-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>L. J. Johnson</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Road Balto., Md. 21212</b>	

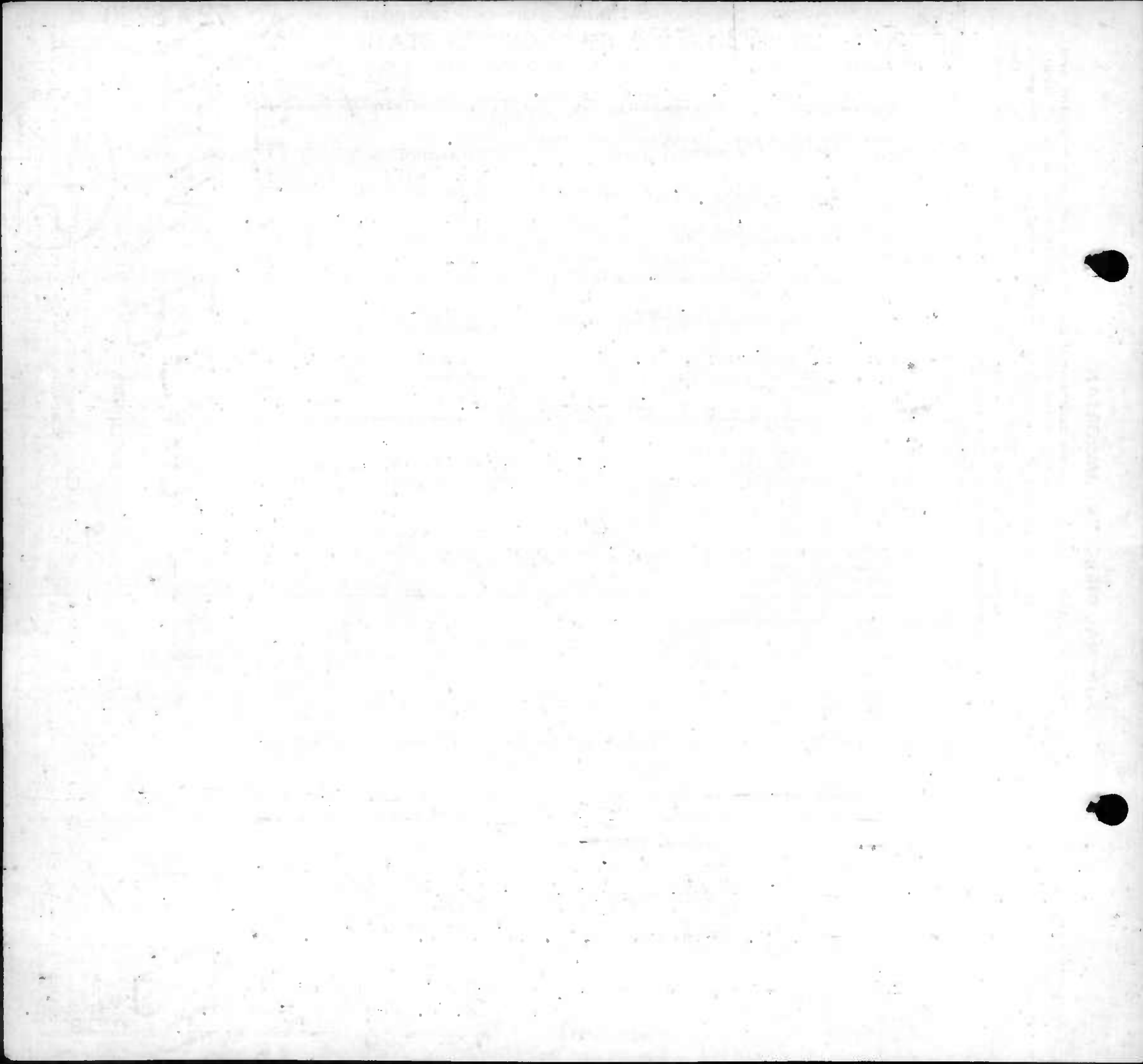




# FUNERAL DIRECTOR: IMPORTANT

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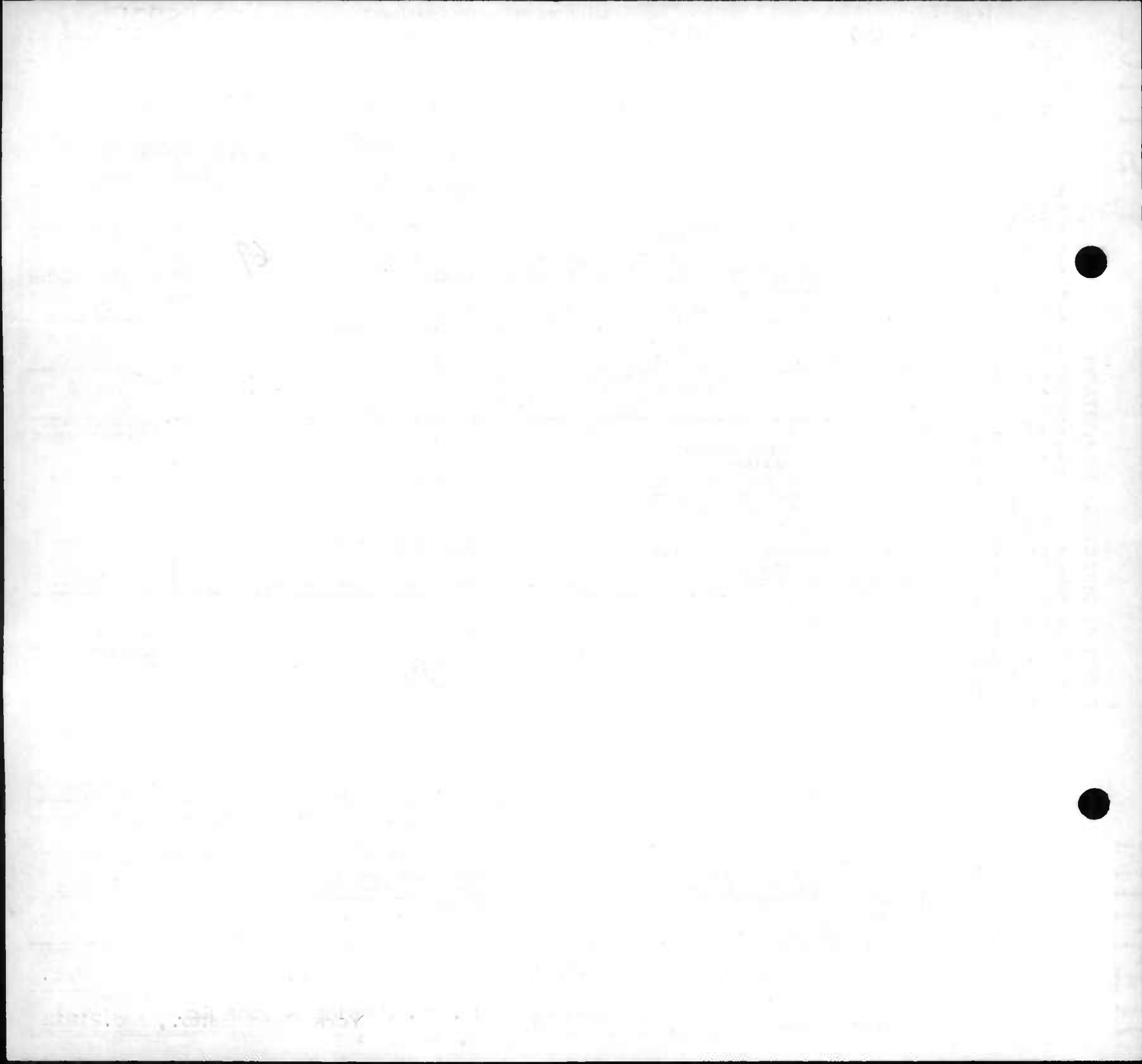
BALTIMORE CITY HEALTH DEPARTMENT				72 08220		72 08220	
7-525				72 08220		72 08220	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>Charles D. Fenhagen, Jr.</b>				2. DATE AND HOUR OF DEATH <b>8/25/72 12:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 Hopkins Apts. 205</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1202</b>			
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>6-1-1882</b>		9. AGE (In years lost birthday) <b>90</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Banker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Charles D. Fenhagen, Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Jane Dungan Corner</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I Army</b>			
16. SOCIAL SECURITY NO. <b>216-14-1323</b>				17. INFORMANT ADDRESS <b>Mr. Corner Fenhagen 4300 Greenway</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis heart disease 2 yrs.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Arteriosclerosis, generalized 10 yrs.</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>10 yrs.</b>			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <b>Apr 1969</b> to <b>8/25 1972</b> that (I) (we) last saw the deceased alive on <b>8/22 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.							
23A. SIGNATURE <b>Norman R. Freeman, Jr. M.D.</b>				23B. DATE SIGNED <b>8/25/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Norman R. Freeman, Jr. M.D.</b>	
23D. ADDRESS <b>11 W. 29th St.</b>				24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <b>Burial 8-28-72</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Greenmount Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>				25B. NAME OF REGISTRAR <b>H. W. Jenkins Sons Co.</b>			
25C. FUNERAL DIRECTOR ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b>							



# FUNERAL DIRECTOR: IMPORTANT

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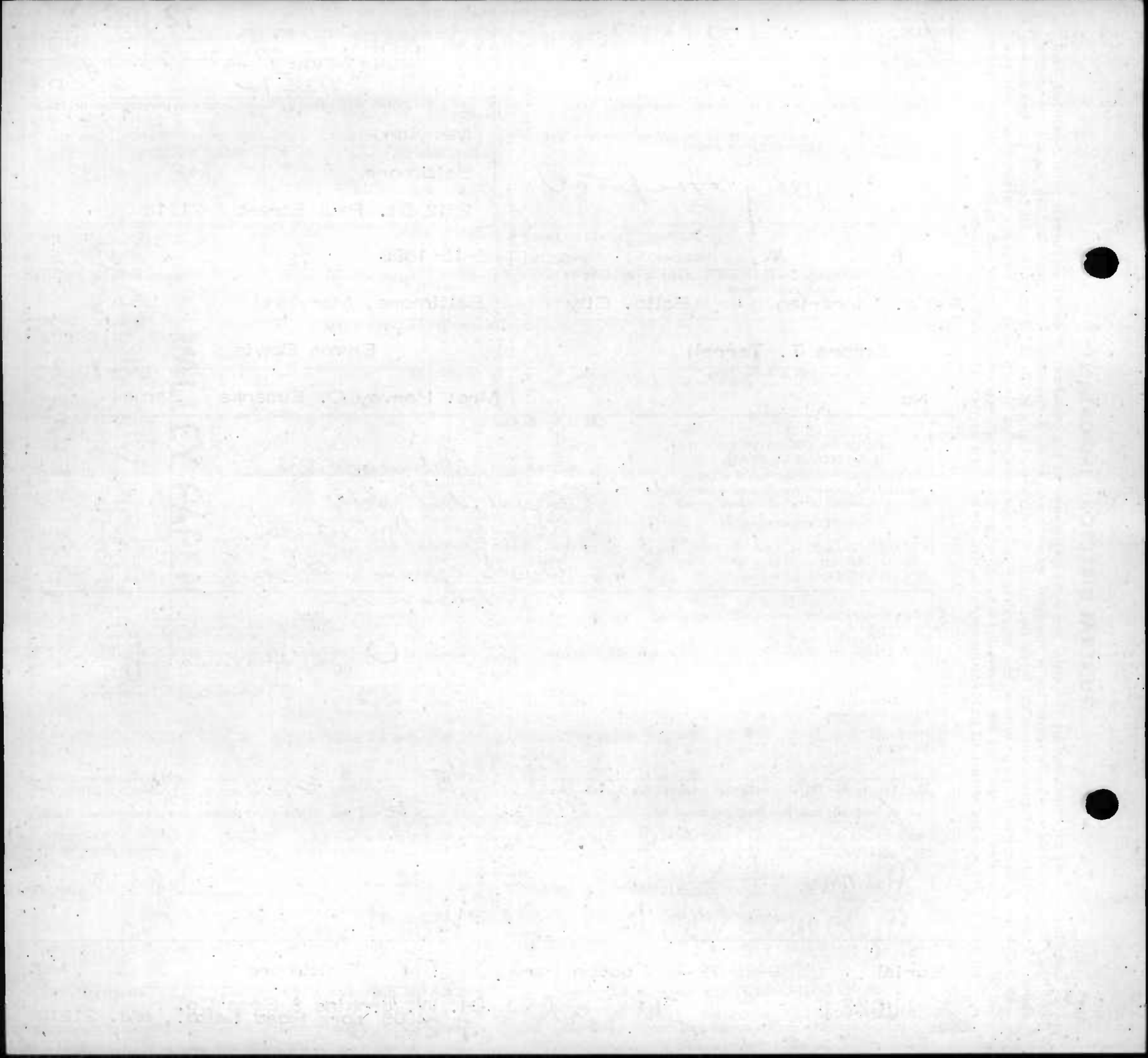
M-600		72 08221		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 08221 REG. NO. 72 08221 STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <u>Morr, Elizabeth A.</u>				2. DATE AND HOUR OF DEATH <u>Aug. 27-72</u> <u>2 pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2714</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hosp.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>4401 Roland Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-20-02</u>	9. AGE (In years last birthday) <u>69</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Stanley Makares</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>22014-8944</u>		17. INFORMANT <u>Lawrence S. Morr</u> ADDRESS <u>2823-64th Ave. Chevy, M.D.</u>	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Central failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>Dr.</u> (this hospital) attended the deceased from <u>Aug. 24</u> 19 <u>72</u> to <u>Aug. 27</u> 19 <u>72</u> that <u>Dr.</u> (we) last saw the deceased alive on <u>Aug. 27</u> 19 <u>72</u> and that <u>Dr.</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>Dr.</u> (We) (did) (not) view the body after death.							
23A. SIGNATURE <u>Chung-Hsien Yu M.D.</u>				23B. DATE SIGNED <u>8/27/72</u>		23C. PHYSICIAN'S NAME (Type) <u>CHUNG-HSIEN YU M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>8-30-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Balto.</u>				24E. ADDRESS <u>H. W. Jenkins &amp; Sons Co., 4905 York Road Balto., Md. 21212</u>		24F. ADDRESS <u>21218</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 28 1972</u>				25B. NAME OF REGISTRAR <u>Adrian J. Horton</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08222	
<div style="display: flex; justify-content: space-between;"> <span>T-640</span> <span>72 08222</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Estelle Duke Terrell		8/25/72 3:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY			
37 Mercy Hospital		Maryland			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2612 St. Paul Street 21218			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-15-1899	73	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret'd. Librarian		Balto. City		Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Embrea T. Terrell			Emma Bowie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Mrs. Harvey C. Eubanks	
				ADDRESS	
				Same	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic heart failure</u> (B) <u>Chronic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Renal effusion, ascites</u> (C) <u>And generalized edema</u>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 8/25 19 72 to 8/25 19 72, that (1) (we) last saw the deceased alive on 8/25 19 72 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Nicola F. Soergelin				August 26/1972	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Nicola F. Soergelin		Mercy Hospital St. Paul			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8-29-72		Loudon Park	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 28 1972		Audrey K. Horton		H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



72 08223

STATE OF MARYLAND-DEMD  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

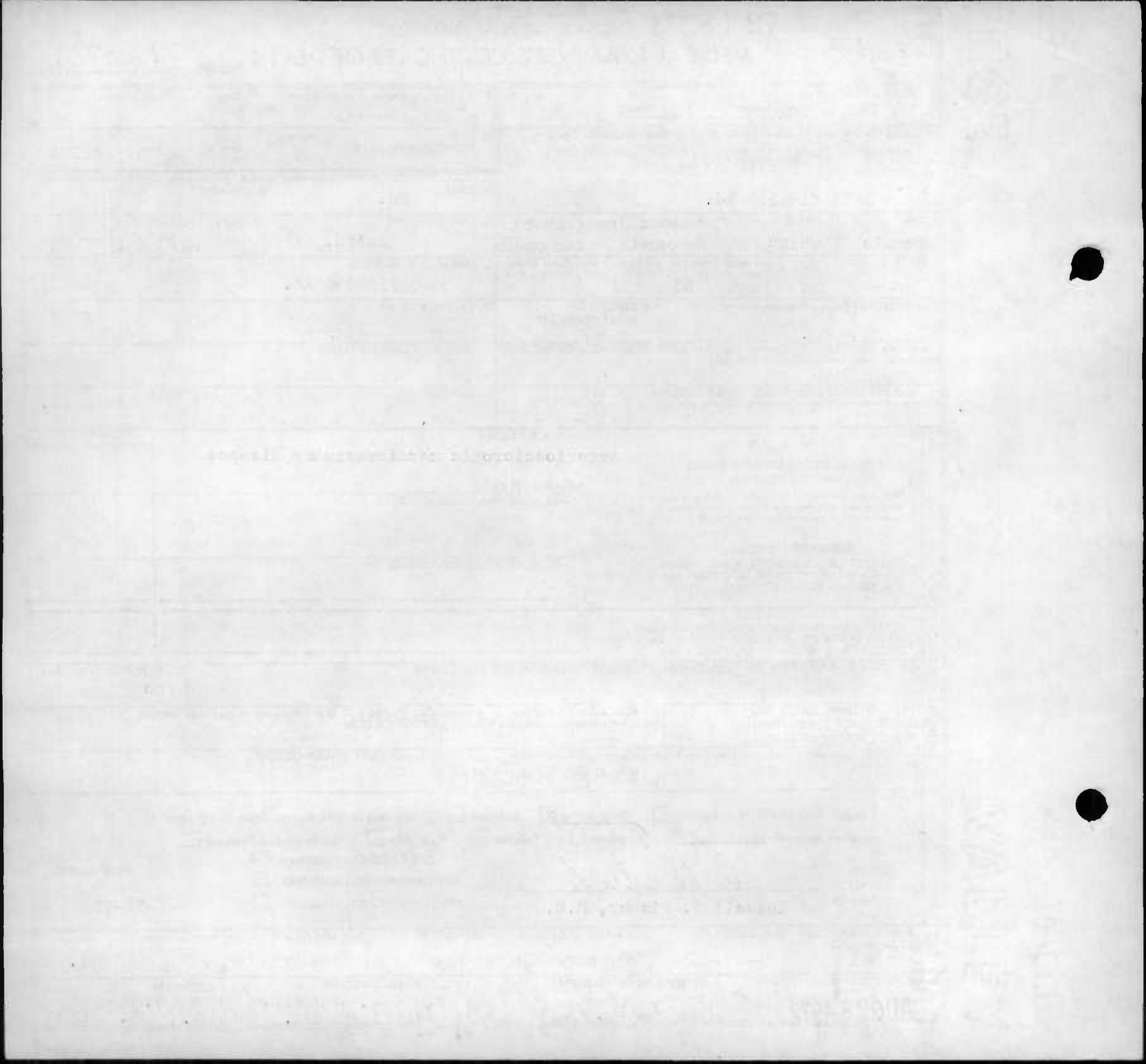
REG. NO.

72 08223

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOROTHY L. PERKINS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3605 Kimble Rd.				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 27 1972 9:30a M.			
6. SEX female				7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6-9-07				10. AGE (in years last birthday) 65		11. BIRTHPLACE (State or foreign country) York, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME John Neater		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 903	
15. MOTHER'S MAIDEN NAME Mary Alice Wolf				16. INFORMANT Mrs. Aliceann Estheridge			
17. SOCIAL SECURITY NO. 213-58-2795				18. ADDRESS 805 Ridgeleigh Rd.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) no							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-28-72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-29-72		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 28 1972		25B. NAME OF REGISTRAR A. J. H. H. H.		25C. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins Sons Co. 4805 York Rd. Balto., Md. 21212			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 08224 CERTIFICATE OF DEATH					REG. NO. 72 08224				
STATE OF MARYLAND-DEMD									
1. NAME OF DECEASED (Type or Print) <b>ELMER MARTIN JACKSON 3RD</b>					2. DATE AND HOUR OF DEATH <b>8/25/72 4:20 PM</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A. A. CO.</b>				
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>					C. CITY OR TOWN <b>ANNAPOLIS</b>				
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER <b>CRABB COVE BYWATER RD.</b>									
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-29-30</b>	9. AGE (in years last birthday) <b>42</b>	11. BIRTHPLACE (State or foreign country) <b>ANNAPOLIS MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Editor</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>NEWSPAPER</b>				
13. FATHER'S NAME <b>ELMER M. JACKSON JR.</b>					14. MOTHER'S MAIDEN NAME <b>MARY WATERS CONRAD</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>214-26-1921</b>		17. INFORMANT <b>MARCIA L. JACKSON #4</b>		
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Arrest</b> <b>4:10 pm</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypoxia + Hypotension</b> <b>1:00 pm</b>				
					(C) <b>Pulmonary Insufficiency</b> <b>NOON</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Peritonitis, Subphrenic abscess, Upper GI Bleeding, Pneumonia</b>					<b>8/3/72</b>				
19A. DATE OF OPERATION <b>8/3/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diverticulitis Breakdown</b>		20A. AUTOPSY (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/31</b> 19 <b>72</b> to <b>8/25</b> 19 <b>72</b> and that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/25</b> 19 <b>72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.									
23A. SIGNATURE <b>David L. Bouwman MD</b>					23B. DATE SIGNED <b>8/25/72</b>			23C. PHYSICIAN'S NAME (Type) <b>DAVID L. BOUWMAN</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>8-28-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ST. ANNES</b>		
24D. LOCATION (City, town, or county) (State) <b>ANNAPOLIS A.A. MD.</b>					25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>				
25B. NAME OF REGISTRAR <b>Dwight H. Johnson</b>					25C. FUNERAL DIRECTOR <b>John M. Taylor Annapolis, Md.</b>				

00001

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

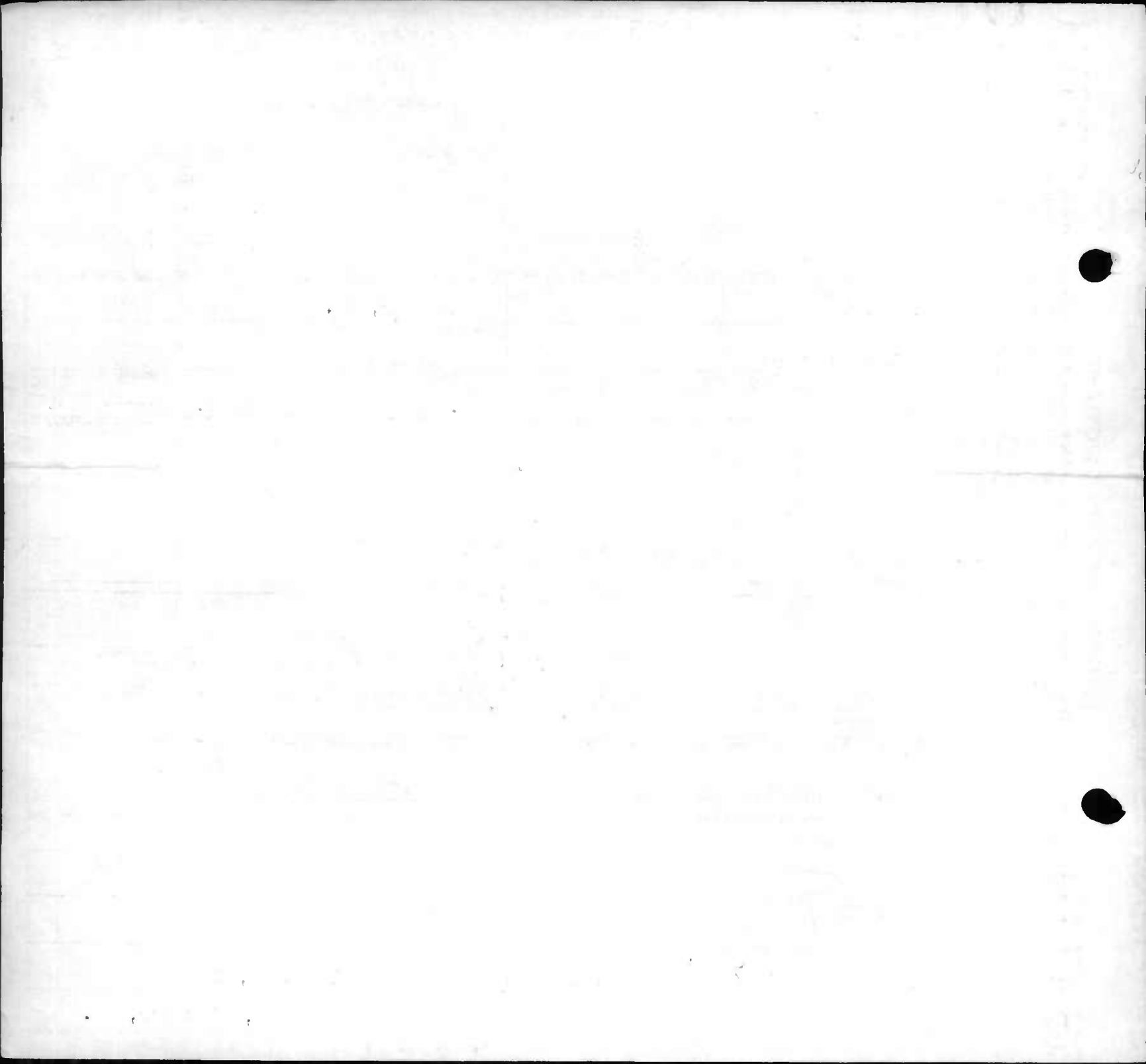
WASH. D.C.

1900

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08225		W-630		72 08225		
BIRTH NO.				REG. NO.				STATE OF MARYLAND-DEATH		
1. NAME OF DECEASED (Type or Print) <b>WARD Carl</b>				2. DATE AND HOUR OF DEATH <b>8/24/72 3:52 PM</b>						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2716</b>						
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <b>3408 St. Ambrose Av. #15</b>										
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/27/46</b>	9. AGE (In years last birthday) <b>26</b>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disability</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>			11. BIRTHPLACE (State or foreign country) <b>Glauster, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Clarence Ward</b>				14. MOTHER'S MAIDEN NAME <b>Louise Ward</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>N</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Ingrid Ward</b>				ADDRESS <b>3408 St. Ambrose Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>uncontrollable bleeding during surgery after replacement of mitral + aortic valves.</b>				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF						
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <b>4/24/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>mitral valve regurgitation aortic stenosis + insufficiency</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical) examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR						
22. I certify that (I) (this hospital) attended the deceased from <b>8/1/72</b> to <b>8/24/72</b> and that (I) (we) lost soul the deceased alive on <b>8/24/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>H. L. EREQUE</b>				23B. DATE SIGNED <b>8/24/72</b>		23C. PHYSICIAN'S NAME (Type) <b>H. L. EREQUE</b>				
23D. ADDRESS <b>Sinai Hospital of Baltimore</b>		23E. NAME OF REGISTRAR <b>Sidney Johnston</b>		23F. FUNERAL DIRECTOR <b>Howard Funeral Home, Glauster, Va.</b>		23G. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/29/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Zion Hill Church Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glauster, Va.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 28 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>Howard Funeral Home, Glauster, Va.</b>		25D. ADDRESS				



U-260

72 08226

HEALTH & MENTAL HYGIENE  
BALTIMORE CITY HEALTH DEPARTMENT

72 08226

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

THOMAS USSERY

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

1905 Christian St.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

8

27

1972

11:58p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

2003

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5/4/47

10. AGE (In years  
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1905 Christian St.

11. BIRTHPLACE (State or foreign country)

Baltimore, MD.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Edgar M. Ussery

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ruth Nichols

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

E. M. Ussery 1905 Christian St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

aspiration of gastric content

(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) post encephalitic mental retardation

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S

NAME (Type) Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Deputy Chief Medical Examiner

8-28-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8/31/72

24C. NAME OF CEMETERY or CREMATORY

Int. Olivet Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 29 1972

25B. NAME OF REGISTRAR

Sidney Whorton

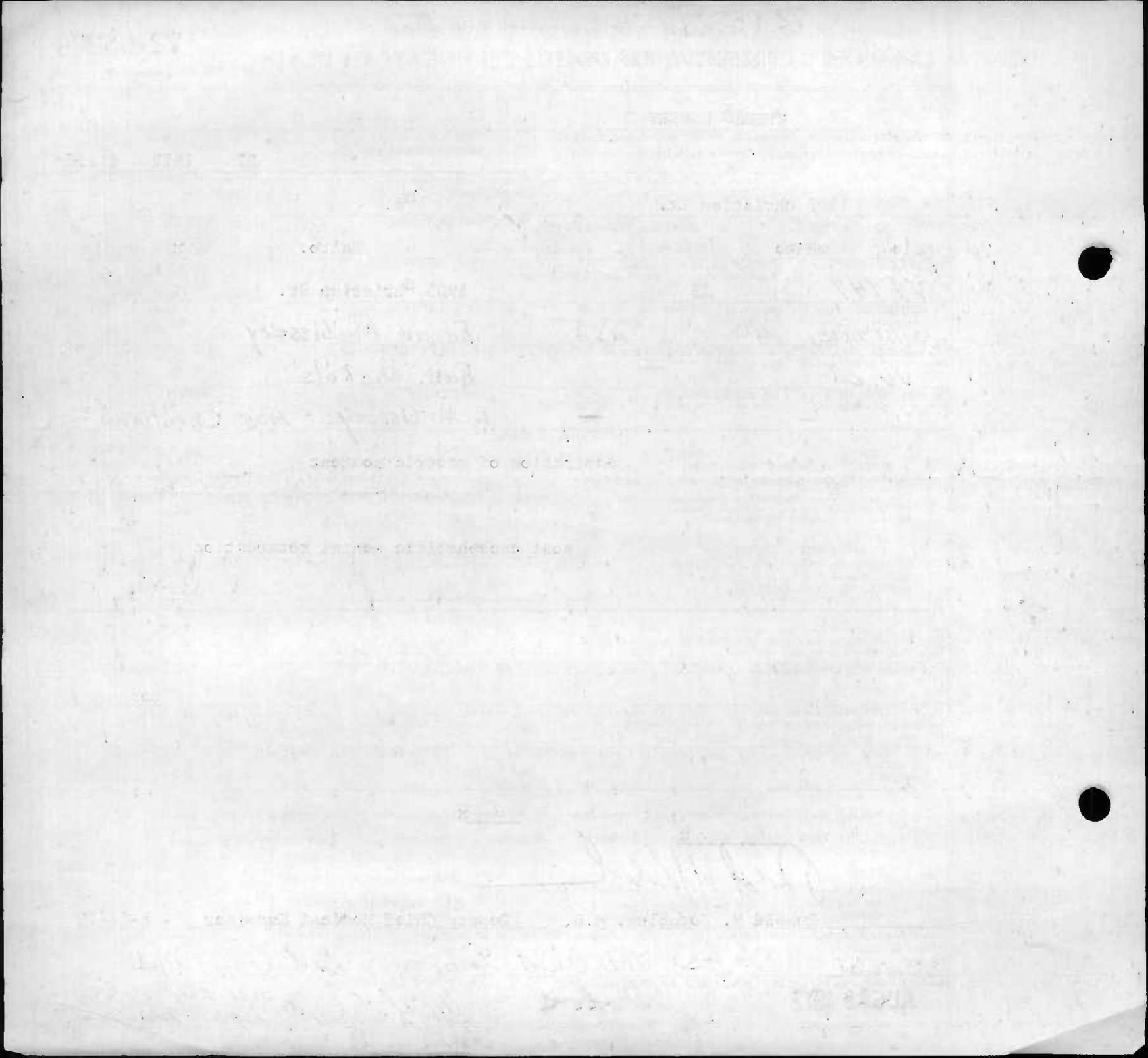
25C. FUNERAL DIRECTOR

Joe L. Schmitt

ADDRESS

2101 Friedman Ave  
Baltimore, Md. 21223

72 08226

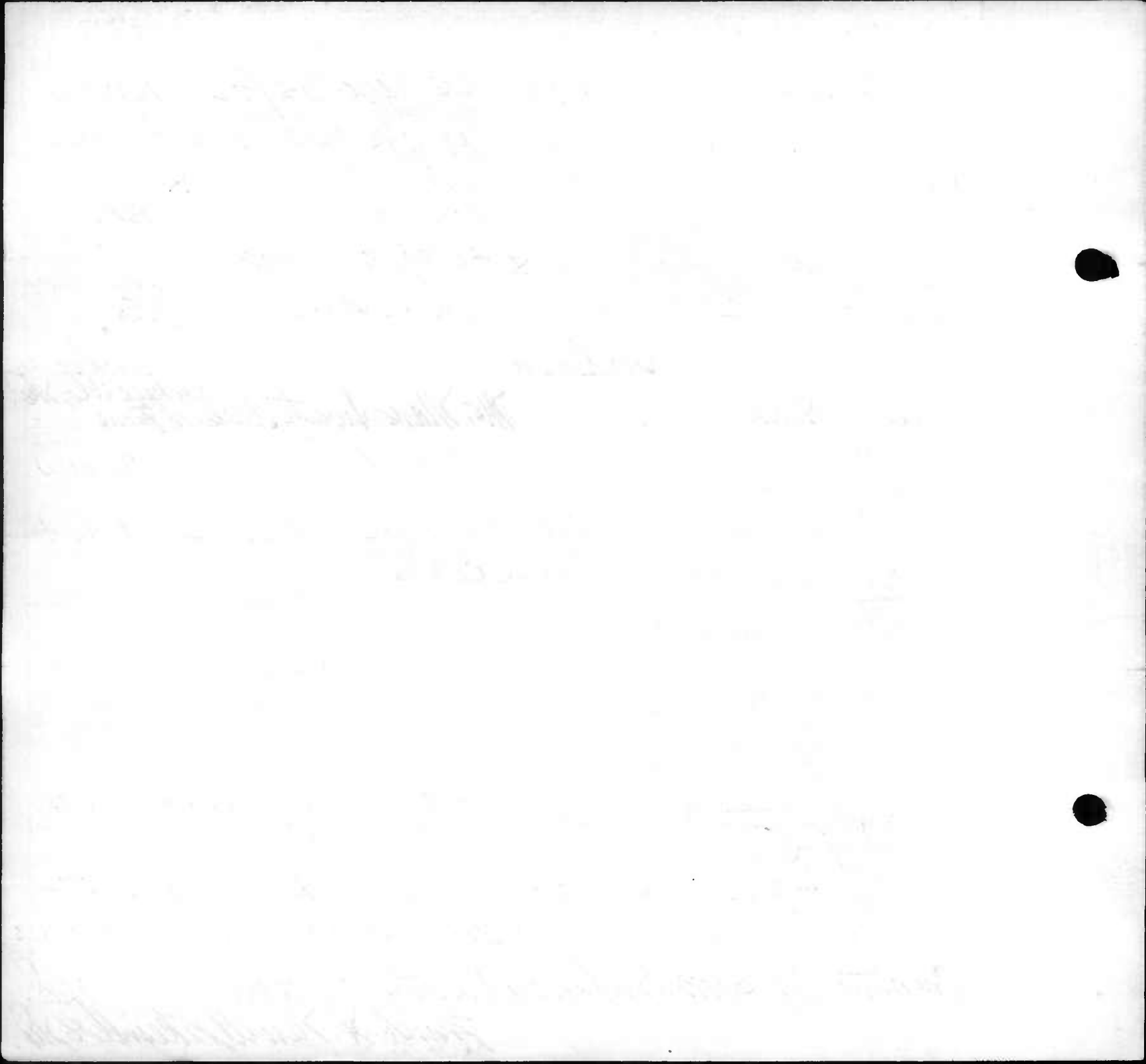




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

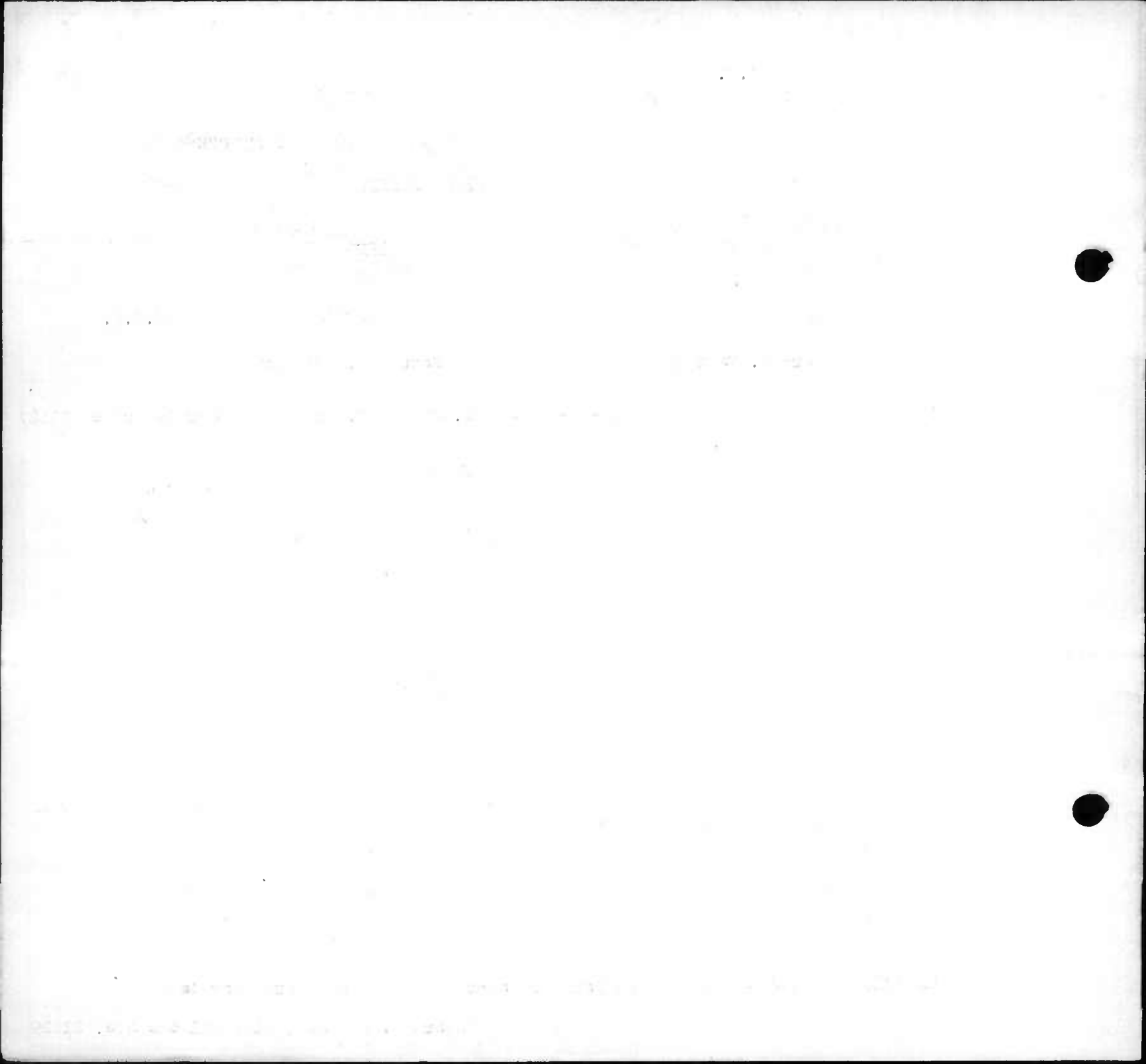
D-612		72 08227		BALTIMORE CITY HEALTH DEPARTMENT		72 08227	
<b>CERTIFICATE OF DEATH</b>				REG. NO.			
BIRTH NO.				STATE OF MARYLAND - DHEMT			
1. NAME OF DECEASED (Type or Print) <b>ALBERT V. DERBYSHIRE</b>				2. DATE AND HOUR OF DEATH <b>AUG 25/72 12:15A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH CHARLES GEN. HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b>			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>408 W. SARATOGA ST. 401</b>			
5. SEX <b>M</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>8/27/03</b>	9. AGE (in years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FUR DESIGNER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FURS</b>		11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>182-03-3244</b>		17. INFORMANT <b>Mr. Mario Swartz, Cockeysville, Md.</b>		ADDRESS	
18. <b>34801</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>AMYOTROPHIC LATERAL</b>		<b>20 MIN</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>SCLEROSIS</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:				<b>1 YEAR</b>	
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>6/7</b> 19 <b>72</b> to <b>8/25</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/24</b> 19 <b>72</b> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Mrs. E. Rivera MD</b>				23B. DATE SIGNED <b>8/25/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>LOUIS E. RIVERA MD</b>				23D. ADDRESS <b>6505 COPPER RIDGE 202, BALTO</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>Aug 29 1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenwood Cemetery, Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Disinfectant</b>		25C. FUNERAL DIRECTOR <b>Frank H. Newell</b>		ADDRESS <b>Baltimore, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

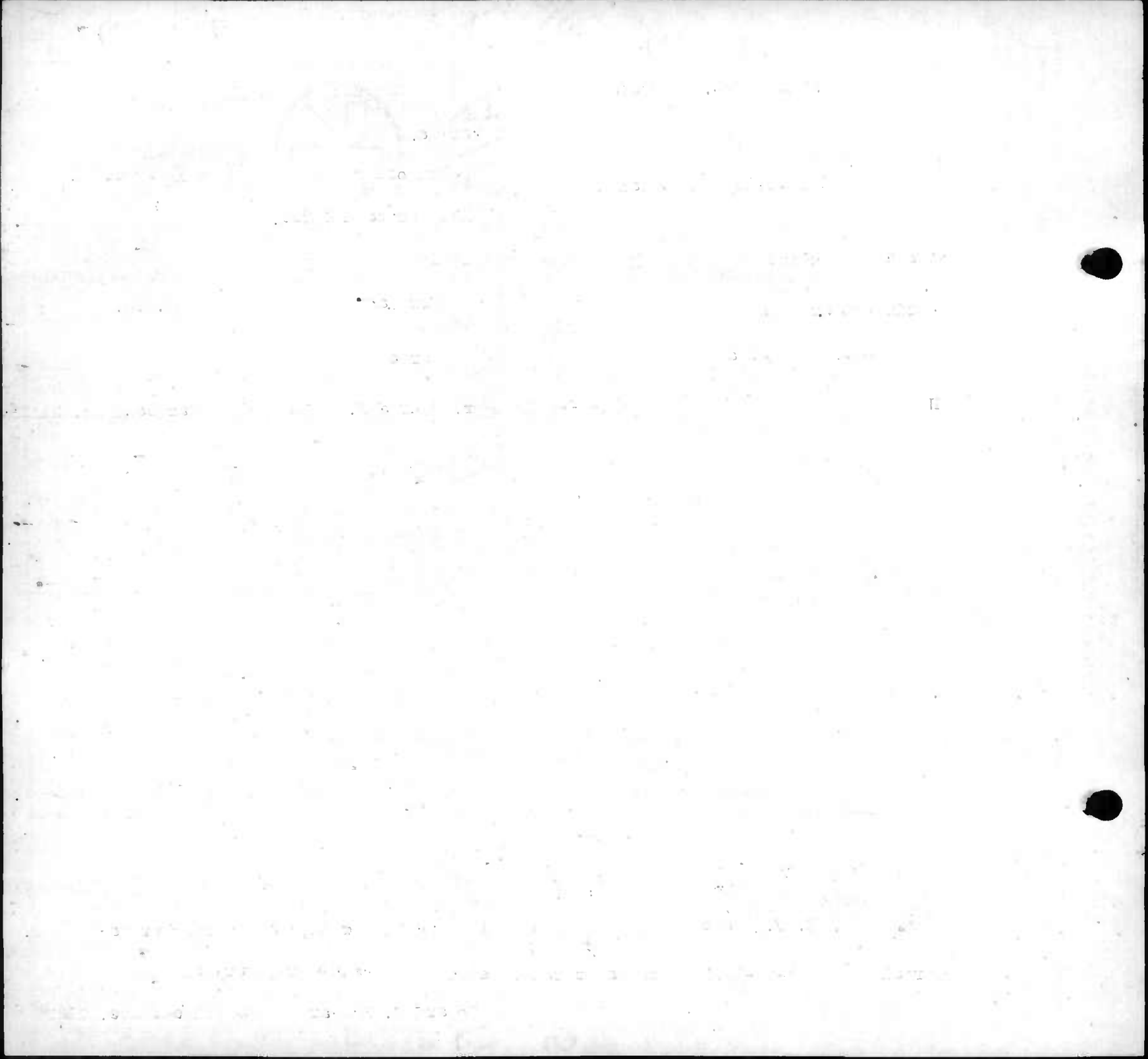
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-620		72 08228		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 08228	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mildred Krug</i>				2. DATE AND HOUR OF DEATH <i>8-25-72</i> <i>2:30</i> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				STATE OF MARYLAND - DEPT. OF HEALTH			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i> B. COUNTY <i>BALTIMORE</i>				C. CITY OR TOWN <i>ARBUTUS</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<i>Lutheran Hospital</i>		E. STREET AND NUMBER <i>1309 CUSH DR.</i>							
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1906</i>	9. AGE (In years last birthday) <i>65</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
13. FATHER'S NAME <i>Robert H. Fahrney</i>		14. MOTHER'S MAIDEN NAME <i>Sarah E. Roeder</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-40-4087A</i>		17. INFORMANT ADDRESS <i>Mr. Elwood H. Krug, 1209 Circle Drive 21227</i>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <i>Pulmonary Edema</i> DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES		(B) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>8-22-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>8-22-1972</i> to <i>8-25-1972</i> that (I) (we) last saw the deceased alive on <i>8-25-72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>J. H. Siddiqui</i> M.D.		23B. DATE SIGNED <i>8-25-72</i>		23C. PHYSICIAN'S NAME (Type) <i>J. H. Siddiqui</i> M.D.		23D. ADDRESS <i>Lutheran Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>CREMATION</i>		24B. DATE <i>8-28-1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Crematory</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 29 1972</i>		25B. NAME OF REGISTRAR <i>Arthur J. Hubbard</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		ADDRESS <i>4107 Wilkens Ave. 21229</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08229	
BIRTH NO. 0-540 72 08229				STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ANNA M. O'NEAL			August 26, 1972		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital			A. STATE Maryland		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1336 Sargeant Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-1889	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Char Woman			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Hlafka			14. MOTHER'S MAIDEN NAME Marie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-28-7073		17. INFORMANT Mr. George J. O'Neal, 1336 Sargeant St. 21223
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH (A) IMMEDIATE CAUSE Circulatory Fibrillation DUE TO, OR AS A CONSEQUENCE OF: (B) Anterior - Ischemic C.V.D. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Two months Ten years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 28 19 63 to Aug 26 19 72, that (I) (we) last saw the deceased alive on Aug 19 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. F. Kates M.D.				23B. DATE SIGNED 8-28-72	
23C. PHYSICIAN'S NAME (Type) H. F. Kates				23D. ADDRESS 517 Scott Street, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-29-1972		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 29 1972		25B. NAME OF REGISTRAR Sidney H. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08230	
BIRTH NO. H-630 72 08230				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>HARDY, MARJORY MARIE</b>			2. DATE AND HOUR OF DEATH <b>AUGUST 22, 1972 3:58 PM M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>40 ST AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>WOODLAWN</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3111 THORNEFIELD ROAD 21207</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07 27 17</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COMPUTER SPECIALIST</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SOCIAL SECURITY</b>		11. BIRTHPLACE (State or foreign country) <b>WISCONSIN</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Charles Hoffman</b>		
14. MOTHER'S MAIDEN NAME <b>JOSEPHINE BASEFORD</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>477 16 4541</b>			17. INFORMANT <b>WILKENS AVE BALTIMORE MARYLAND</b> <b>ST AGNES HOSPITAL RECORDS CATON &amp;</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>222X-260.9</b> <b>MYOCARDIAL INFARCTION</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MORBID OBESITY.</b> <b>DIABETIS MELLITUS.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>8-22-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MORBID OBESITY</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>AUGUST 13 19 72</b> to <b>AUGUST 22 19 72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>AUGUST 22 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <b>Sabanayagam</b>				23B. DATE SIGNED <b>8/22/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. P. SABANAYAGAM, M.D.</b>				23D. ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-30-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>			



WASH, DC 1000 1000 1000

TO DIRECTOR, FBI

FROM SAC, NEW YORK

RE NEW YORK TELETYPE TO BUREAU, JANUARY 9, 1960

URGENT 1000 1000 1000

COMMUNIST PARTY, USA - NEW YORK

RE NEW YORK TELETYPE TO BUREAU, JANUARY 9, 1960

URGENT 1000 1000 1000

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08231		REG. NO. 72 08231	
BIRTH NO. B-220				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Backhaus Martha M</u>				2. DATE AND HOUR OF DEATH <u>August 25, 1972 7:10 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2834</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4648 COLEHERNE RD</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-91</u>		9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>
13. FATHER'S NAME <u>Paul Niesch</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Matthesius</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Helen Backhaus, 4648 Coleherne Rd. 21229</u>		
18. <u>427.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Pneumonia - Chronic</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic obstructive lung disease</u> <u>Congestive Heart Failure</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic obstructive lung disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u> (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If In Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Harry R. Jacobson M.D.</u>				DEGREE		23B. DATE SIGNED <u>8-25-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harry R. Jacobson</u>				23D. ADDRESS <u>HARRY R. JACOBSON.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-29-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 29 1972</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 2122</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08232</b>	
72 08232 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEATH	
BIRTH NO. <b>S-353</b>		1. NAME OF DECEASED (Type or Print) <b>STANDIFORD, CHARLES</b>			
2. DATE AND HOUR OF DEATH <b>8/27/72 6 AM.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>U.S.A.</b>	
C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>N. Charles St. Balto 18.</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/11/13</b>	9. AGE (In years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Body &amp; Furniture Auto Shop</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>not known.</b>		14. MOTHER'S MAIDEN NAME <b>not known.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Chad</b>	
18. <b>57193143710</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio-respiratory arrest - Pulmonary embolism</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>chronic alcoholic - Liver cirrhosis</b>			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>8/13</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>8/13</b> 19 <b>72</b> to <b>8/27</b> 19 <b>72</b> that (H) (we) last saw the deceased alive on <b>8/27</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Shocair</b>				23B. DATE SIGNED <b>8/27/72.</b>	
23C. PHYSICIAN'S NAME (Type) <b>HAWYA SHOCAIR</b>				23D. ADDRESS <b>Union Memorial Hospital Baltimore Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/1/72</b>		24C. NAME of CEMETERY or CREMATORY <b>SATERS</b>	
24D. LOCATION <b>BALTO, CO., MD.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Dr. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Paul G. [Signature]</b>	
ADDRESS <b>3617 Chestnut Ave.</b>					

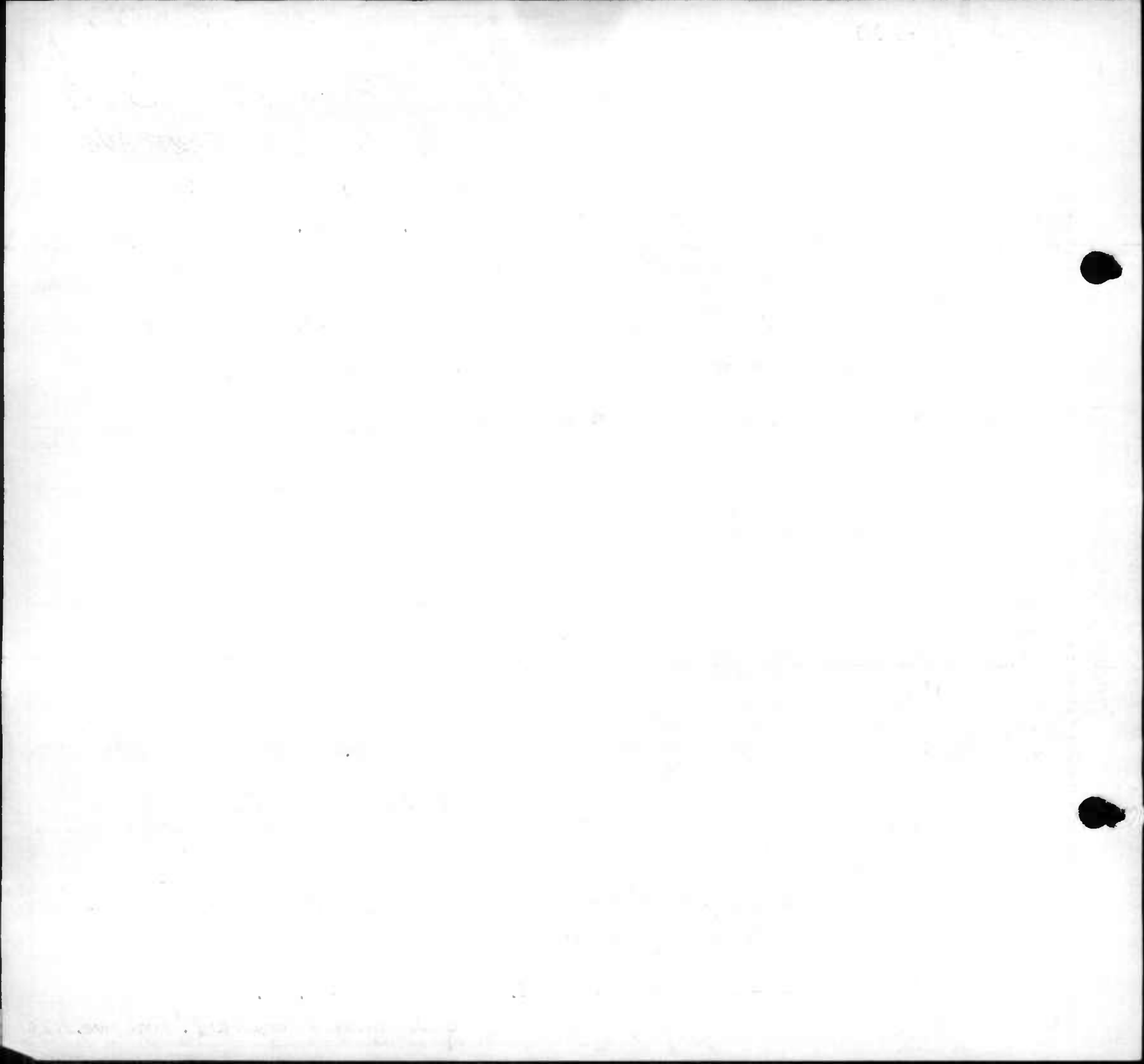
8/4/72 - Melchor N.H.  
2817 Miles Ave.

et

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		72 08233		BALTIMORE CITY HEALTH DEPARTMENT		72 08233	
<b>CERTIFICATE OF DEATH</b>				REG. NO. <b>STATE OF MARYLAND-DEME</b>			
1. NAME OF DECEASED (Type or Print)		JOHN E MOREAU		2. DATE AND HOUR OF DEATH		8-26-72 3 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME &amp; HOSP</b> <b>35 BALTO</b>				A. STATE <b>MD</b> B. COUNTY <b>724 E. FORT AVE.</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTO MD</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>724 E. Fort Ave.</b>		<b>2402</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>02/23/13</b>	9. AGE (In years last birthday) <b>59</b>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN, BALTO CITY</b>				11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edwin Moreau</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE DUNDAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CANCER OF ESOPHAGUS</b>				<b>6 mos.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CIRRHOSIS OF LIVER</b>							
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NONE</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8-24-72</b> 19 to <b>8-26-72</b> 19 that (I) (we) last saw the deceased alive on <b>8-26-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Bernard Yukna MD</b>				23B. DATE SIGNED <b>8-26-72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>BERNARD YUKNA</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-29-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemt.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR <b>McGully Funeral Home</b>		ADDRESS <b>130 E. Fort Ave. 21230</b>	

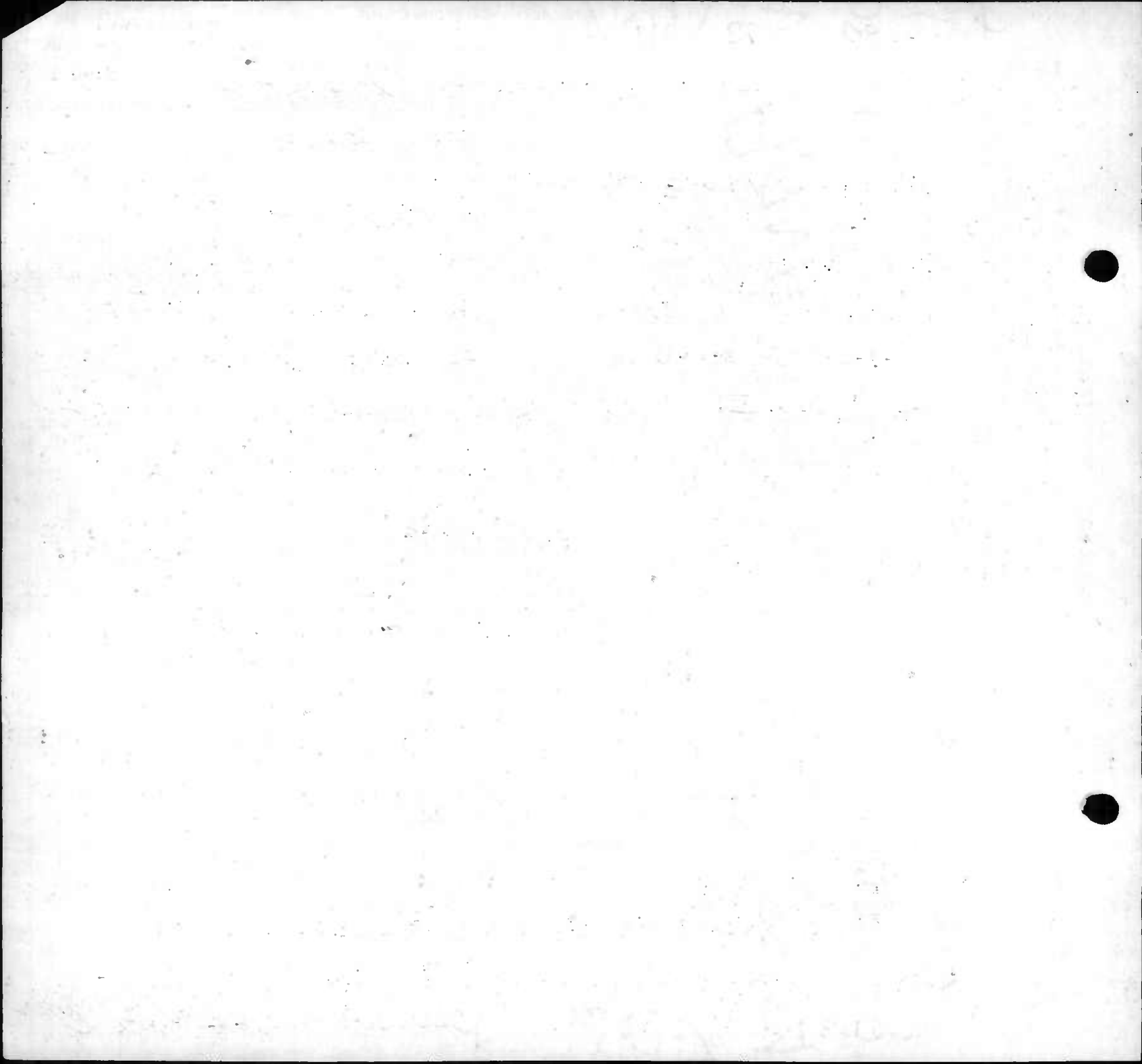




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 08234					72 08234				
R-680					72 08234				
BIRTH NO.					STATE OF MARYLAND-DEMD				
1. NAME OF DECEASED (Type or Print) <b>CHARLES T. REARICK</b>					2. DATE AND HOUR OF DEATH <b>27 AUG. 72</b> <b>9:40 P</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HOUSE-IN-PINES, BELAIRE</b> <b>90</b>					A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>				
					C. CITY OR TOWN <b>DUNDALK</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER <b>21 BROADSHIP</b>				
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>29 AUG 15</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEMIST</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES R. REARICK</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH JEELE</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b> <b>WW II</b>			16. SOCIAL SECURITY NO. <b>213-07-9994</b>		17. INFORMANT <b>LOUISE REARICK, 21 BROADSHIP</b>			ADDRESS <b>21222</b>	
18. <b>436.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <b>Acute Coronary Artery</b> DUE TO, OR AS A CONSEQUENCE OF:				
					(B) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:				
					(C) <b>Coronary artery, not fat. A K Angiogram 4/4/72. Positive evidence of multiple infarction. ASCVD</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>8/23/1972</b> to <b>8/27/1972</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>8/23/1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>A. B. BRADLEY</b>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>8/28/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. B. BRADLEY, MD.</b>					23D. ADDRESS <b>4900 BELAIR RD. 21206</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>			24B. DATE <b>8/29/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>SECURITY PROCESS, INC.</b>			24D. LOCATION (City, town, or county) (State) <b>BALTO, MD. 21222</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>			25B. NAME OF REGISTRAR <b>Andrew Johnston</b>		25C. FUNERAL DIRECTOR <b>CHERICH FUNERAL HOME, BALTO, MD</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 08235 CERTIFICATE OF DEATH				REG. NO. 72 08235	
BIRTH NO. <u>D-654</u>				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <u>ALAN DRUMHELLER</u>		2. DATE AND HOUR OF DEATH <u>AUG 27 1972</u> <u>8:50 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2102</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1324 WASHINGTON BLVD - 21230</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-26</u>	9. AGE (In years last birthday) <u>45</u>	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Trucking Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Stewart Drumheller</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Burns</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>Korea War</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Joan Mae Drumheller - 1324 Wash. Blvd.</u>	
18. <u>410-91</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) <u>ACUTE CORONARY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 16</u> 19 <u>72</u> to <u>Aug 27</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 27</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Virna V. Torres</u> MD		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>VIRNA V. TORRES</u> MD	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/31/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem</u>	
24D. LOCATION (City, town, or county) <u>Dorsey, Md.</u>		24E. STATE (State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>AUG 29 1972</u>	
25B. NAME OF REGISTRAR <u>John J. Howard &amp; Son Inc.</u>		25C. FUNERAL DIRECTOR <u>John J. Howard &amp; Son Inc.</u>		25D. ADDRESS <u>21225</u>	

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R-500

72 08236 STATE OF MARYLAND - DEPT. OF HEALTH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08236

## BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARENCE W. RYAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 24, 1972 7:12 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 24, 1972 7:12 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY HOWARD 6302	
9. DATE OF BIRTH 12/11/22		10. AGE (in years last birthday) 50-49	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. RYAN		14. STREET AND NUMBER 2939 Duvall Road 21797	
15. MOTHER'S MAIDEN NAME SADIE COOK		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II	
17. SOCIAL SECURITY NO. 213-12-1075		18. INFORMANT MRS ANGELA M. RYAN	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries - crushed chest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? State Rte. #32 and #144	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8-24-72 6:15 A.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Driver in auto-truck collision		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 24, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/28/72	
24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 29 1972		25B. NAME OF REGISTRAR Sidney B. Hooten	
25C. FUNERAL DIRECTOR G. TRUMAN SCHWAB		ADDRESS 5151 BALTO. NAT'L. PIKE	

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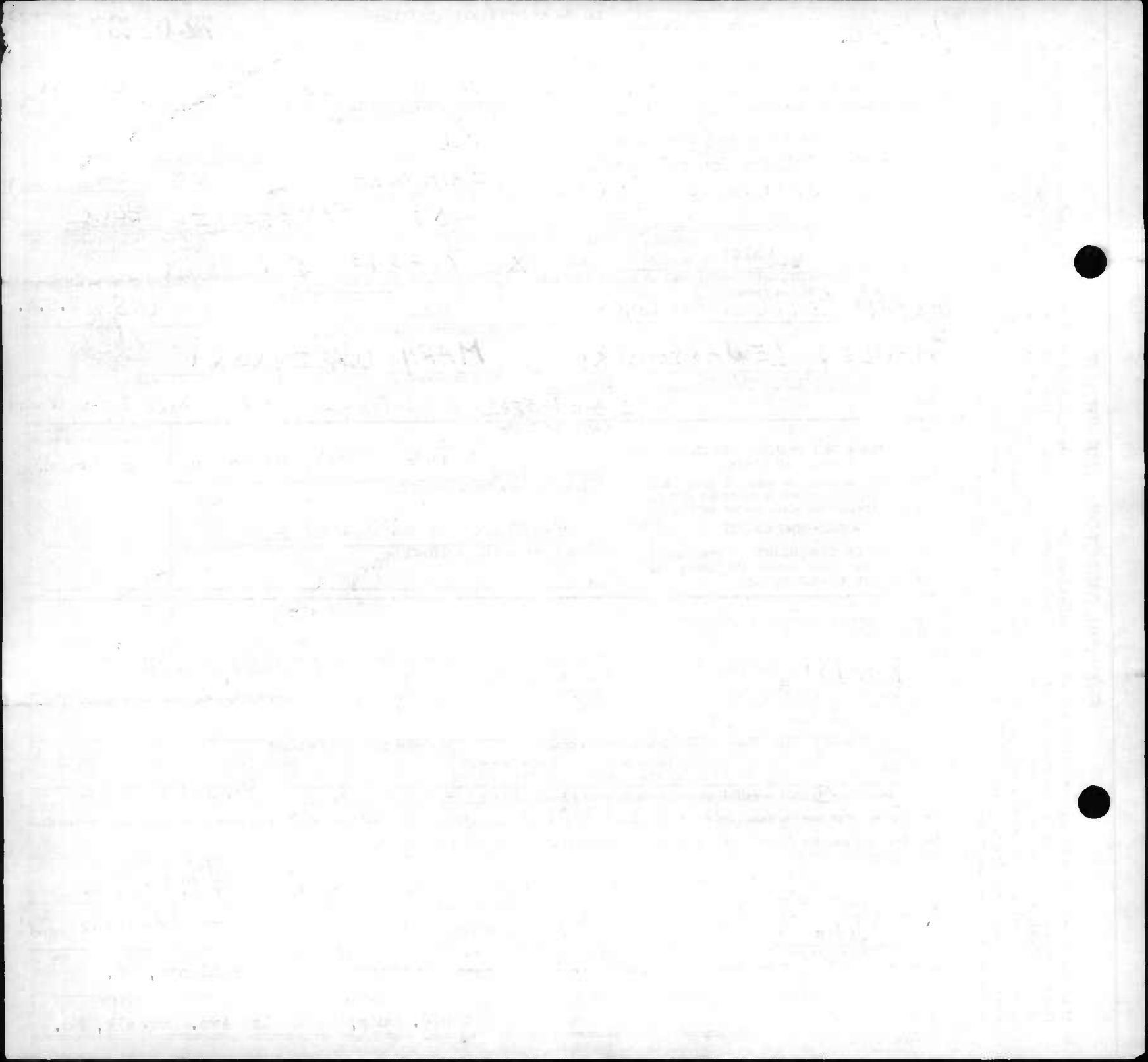
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08237	
1-532 72 08237				X CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND-DHME		P.M.	
1. NAME OF DECEASED (Type or Print) <b>LEWANDOWSKI STEPHEN J.</b>		2. DATE AND HOUR OF DEATH <b>8/23/72 1:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b> <b>43 South Baltimore General</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>459 PEMBROOKE BLVD</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7/25/15</b>	9. AGE (In years last birthday) <b>57</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DENTAL TECHNICIAN EMPLOYED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pa. Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. U.S.A.</b>		13. FATHER'S NAME <b>STANLEY LEWANDOWSKI</b>			
14. MOTHER'S MAIDEN NAME <b>MARY WARZYNSKI</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>			
16. SOCIAL SECURITY NO. <b>213-07-5862</b>		17. INFORMANT <b>J. V. MAGRI M.D.</b> ADDRESS <b>3001 S. HANOVER ST.</b>			
18. <b>160.21</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>DIFFUSE CARCINOMATOSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>	
(B) <b>INTRACRANIAL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF:		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>8/20/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GASTRIC PERFORATION</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>8/20/72</b> 19 to <b>8/23/72</b> 19 that (2) (we) last saw the deceased alive on <b>8/23/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Julio V. Magri M.D.</b>		23B. DATE SIGNED <b>8/23/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Julio V. Magri M.D.</b>	
23D. ADDRESS <b>3001 S. HANOVER ST, BALTIMORE MD.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>8/26/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	

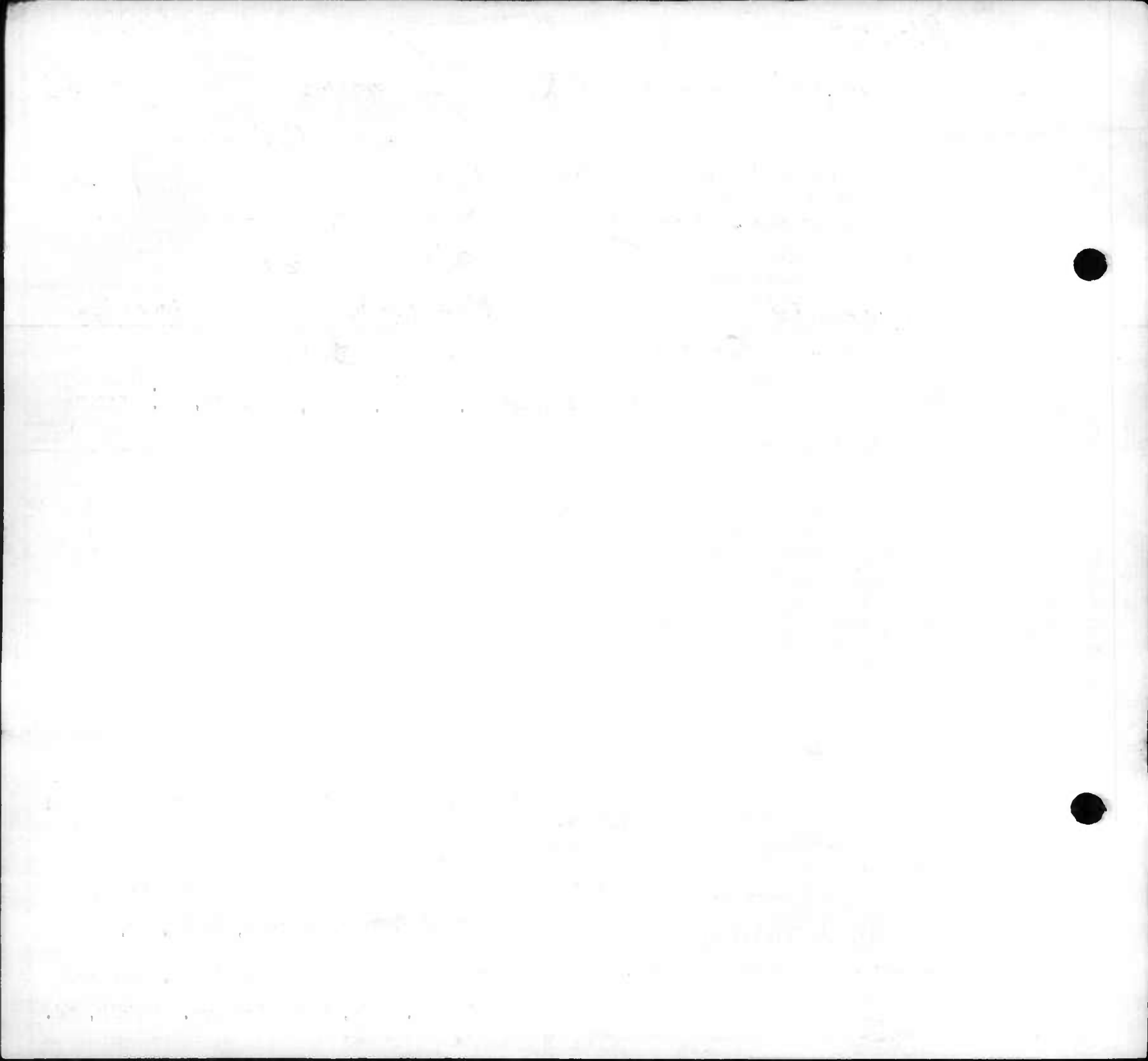




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

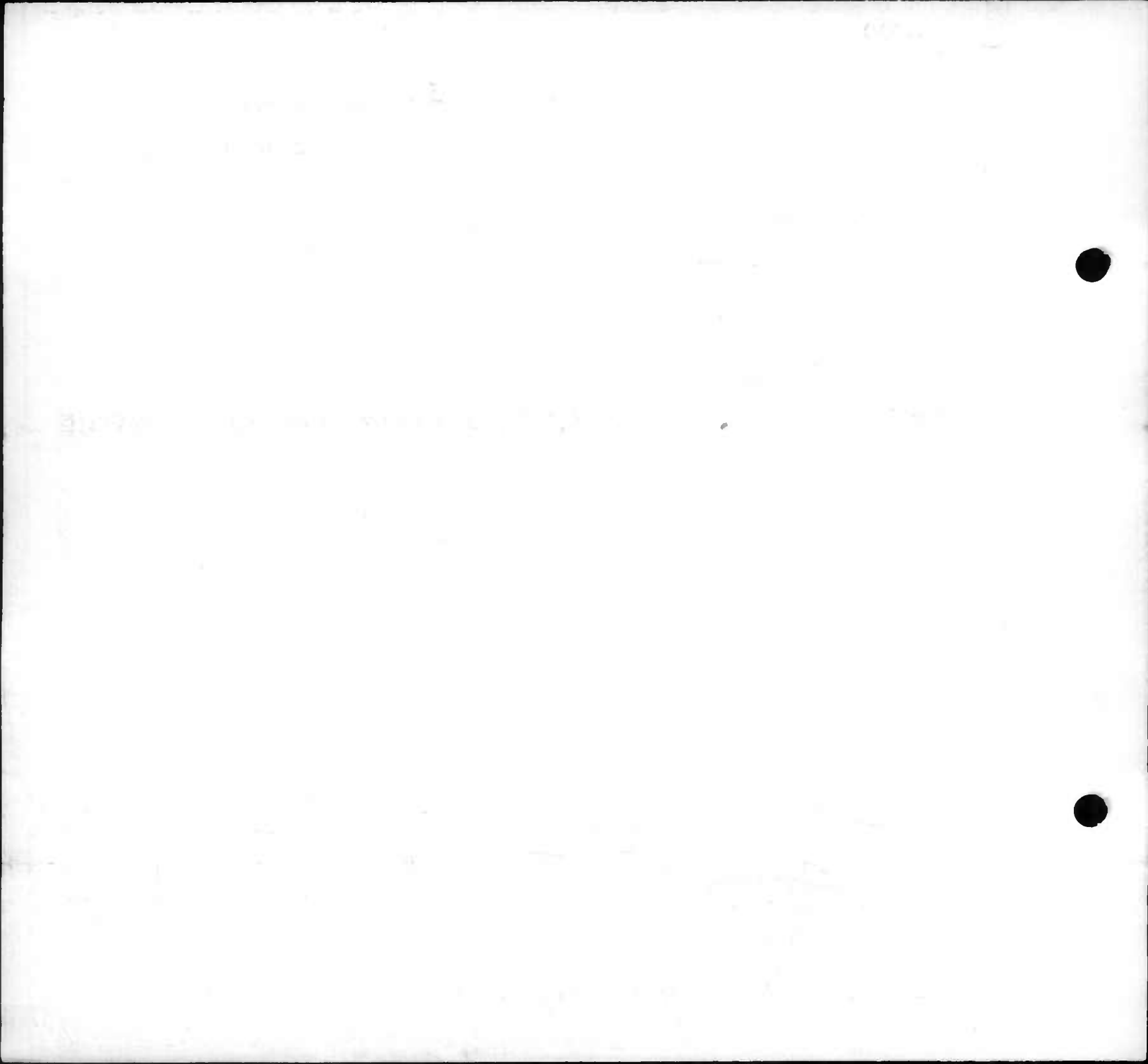
M-620 72 08238		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 08238
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Myers, MRS. Alice R.</b>		2. DATE AND HOUR OF DEATH <b>8/23/72 8 23 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home + Hospital 100 N. Broadway Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>3518 Louth Road</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/27/08</b>	9. AGE (In years last birthday) <b>64</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>America</b>		13. FATHER'S NAME <b>William Casey</b>		
14. MOTHER'S MAIDEN NAME <b>MARY Daley</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>135-14-1080</b>		17. INFORMANT (Husband) <b>Mr. Carl H. Myers, Dundalk, Md. 21222</b>		
18. <b>14591</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>TERMINAL CA (cardiopathy) with secondaries (?) liver and bone.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7/27/72 to 8/23/72</b>		
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>7/27/72</b> to <b>8/23/72</b> and that (I) (we) last saw the deceased alive on <b>8/22/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE <b>R. Swaminathan M.D.</b>		23B. DATE SIGNED <b>8/23/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. A. NAHUM</b>		23D. ADDRESS <b>Church Home &amp; Hospital, Balto. Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>8/26/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Crematory</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		
25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08239	
72 08239				STATE OF MARYLAND - DEPT. OF HEALTH	
BIRTH NO. Y-500		1. NAME OF DECEASED (Type or Print) <u>Thomas Carmelo Vienna SR</u>		2. DATE AND HOUR OF DEATH <u>8/27/72 7:45 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>University State Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>		5. CITY OR TOWN <u>Essex</u>	
6. SEX <u>M</u> 7. RACE <u>W</u> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>10-16-12</u>		10. AGE (In years last birthday) <u>59</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Time D.C. Freight Lines Penn.</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>	
13. FATHER'S NAME <u>Joseph H Vienna</u>		14. MOTHER'S MAIDEN NAME <u>Mary Castino</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>218-01-9080</u>		17. INFORMANT <u>AUGUSTA VIENNA</u>	
18. <u>162.1 I</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Carcinomatosis</u>			
		(B) <u>Carcinoma of the lung</u>			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>N</u> (this hospital) attended the deceased from <u>8-26</u> 19 <u>72</u> to <u>8-27</u> 19 <u>72</u> that (I) <u>we</u> last saw the deceased alive on <u>8/26</u> 19 <u>72</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>Alfredo Lopez-Rasim</u>		23B. DATE SIGNED <u>8/27/72</u>		23C. PHYSICIAN'S NAME (Type) <u>ALFREDO LOPEZ-RASIM</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/31/72</u>		24C. NAME of CEMETERY or CREMATORY <u>HOLY REDEEMER</u>	
24D. LOCATION <u>BALTO. MD.</u>		24E. NAME of REGISTRAR <u>Anthony J. ...</u>		24F. FUNERAL DIRECTOR <u>Gravely Funeral Home</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 29 1972</u>		25B. NAME OF REGISTRAR <u>Anthony J. ...</u>		25C. FUNERAL DIRECTOR <u>Gravely Funeral Home</u>	
25D. ADDRESS <u>300 ...</u>		25E. ADDRESS <u>2122 ...</u>		25F. ADDRESS <u>...</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08240	
W436		72 08240		-CERTIFICATE OF DEATH	
BIRTH NO.		STATE OF MARYLAND			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WALDRON, HARVEY COPELAND		AUGUST 22, 1972 7:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		BALTIMORE	
40 ST AGNES HOSPITAL		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		601 MAIDEN CHOICE LANE		21228	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5/30/83	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
GROCER		DOWNS GROCERY		VIRGINIA	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
HIRAM WALDRON		MARY ANN (COPELAND)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		217 32 5166		BALTIMORE MARYLAND	
		CAUSE OF DEATH		ADDRESS	
				21229	
				ST AGNES HOSPITAL CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:		about 5 days	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		about 6 days	
DISEASES OR CONDITIONS, if only giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		Intertrochanteric Fr of rt hip.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
8/17/72		Fr of rt hip.		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Nursing Home		601 Maiden Choice Lane	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
Aug. 12 1972		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		patient fell.	
22. I certify that (X) (this hospital) attended the deceased from AUGUST 13 1972 to AUGUST 22 1972, that (X) (we) last saw the deceased alive on AUGUST 22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Tee-Shring We				8/23/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
T-S We				KENS AVE BALTIMORE 21229	
				ST AGNES HOSPITAL RECORDS CATON & WIL-	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		8/26/72		MT. OLIVET CEMETERY	
				LOVETTSVILLE, VIRGINIA	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 29 1972		Sidney Johnston		26 Howard Strong - 3207 West North Ave	

ST. LOUIS HOSPITAL  
ST. LOUIS, MISSOURI  
JULY 20, 1933  
ST. LOUIS HOSPITAL  
ST. LOUIS, MISSOURI  
JULY 20, 1933  
ST. LOUIS HOSPITAL  
ST. LOUIS, MISSOURI  
JULY 20, 1933

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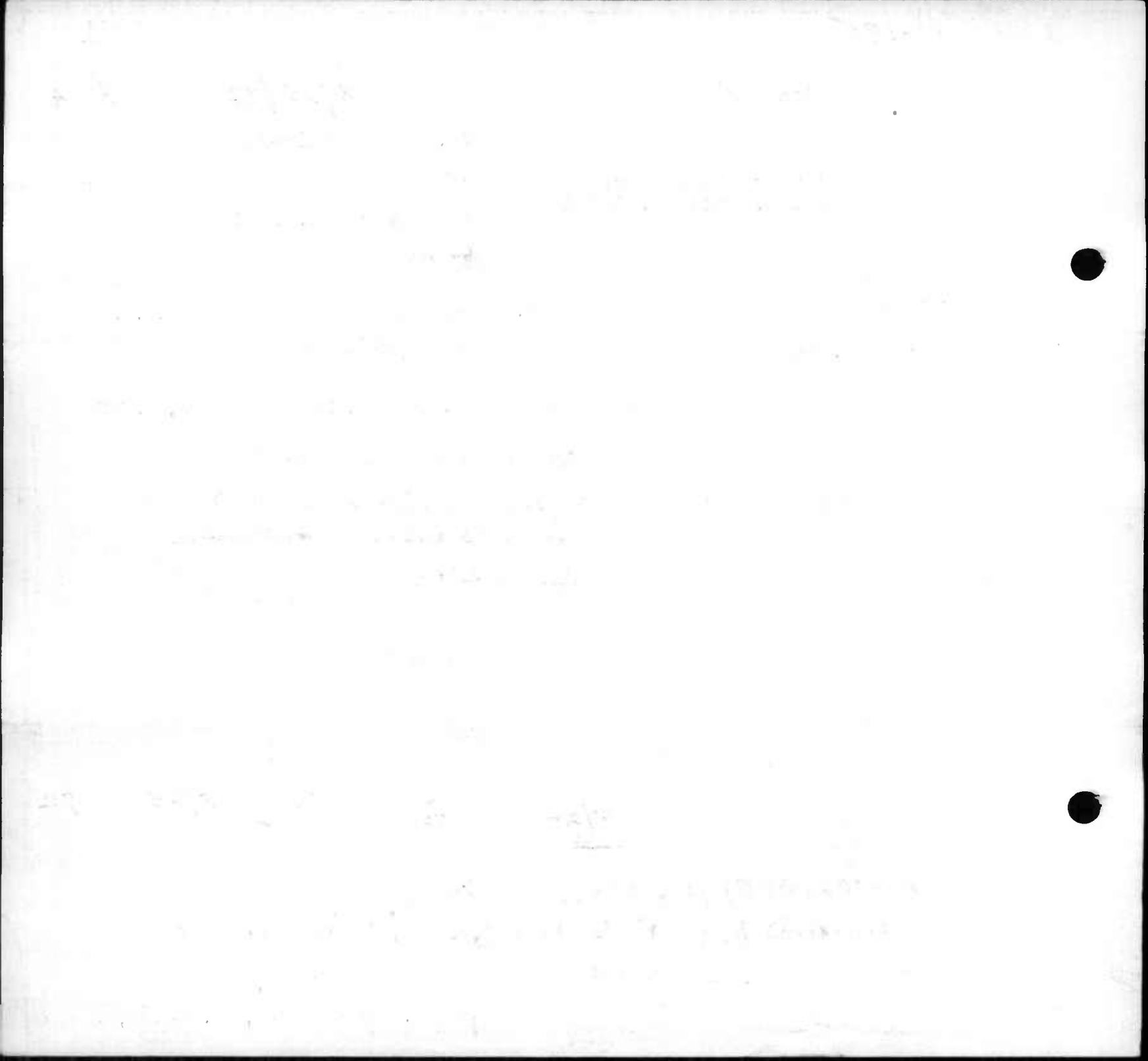
ST. LOUIS HOSPITAL  
ST. LOUIS, MISSOURI  
JULY 20, 1933



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08241	
72 08241				STATE OF MARYLAND-DEATH	
BIRTH NO. <u>N-635</u>				1. NAME OF DECEASED (Type or Print) <u>Louisa Norton</u>	
2. DATE AND HOUR OF DEATH <u>8/25/72</u> <u>3</u> <u>A</u> M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Century Home, Inc. 102 N. Paca St. 21201</u>	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Edgemere</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>3108 Lynch Rd. 21219</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1882</u>	9. AGE (In years lost birthday) <u>89</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Haas Clothing Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William H. Norton</u>			
14. MOTHER'S MAIDEN NAME <u>Mary M. Schoeblein</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>215018096</u>		17. INFORMANT ADDRESS <u>Mr. George T. Nizer 3108 Lynch Rd. 21219</u>			
18. <u>412.41</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) <u>Cardio Respiratory Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVA (B) Gen &amp; Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Senility</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> <u>1972</u> to <u>8/25</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>8/24</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>William H. Norton</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>William H. Norton MD</u>	
23D. ADDRESS <u>6615 Reisterstown Rd</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Aug. 28-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 29 1972</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md 21222</u>	

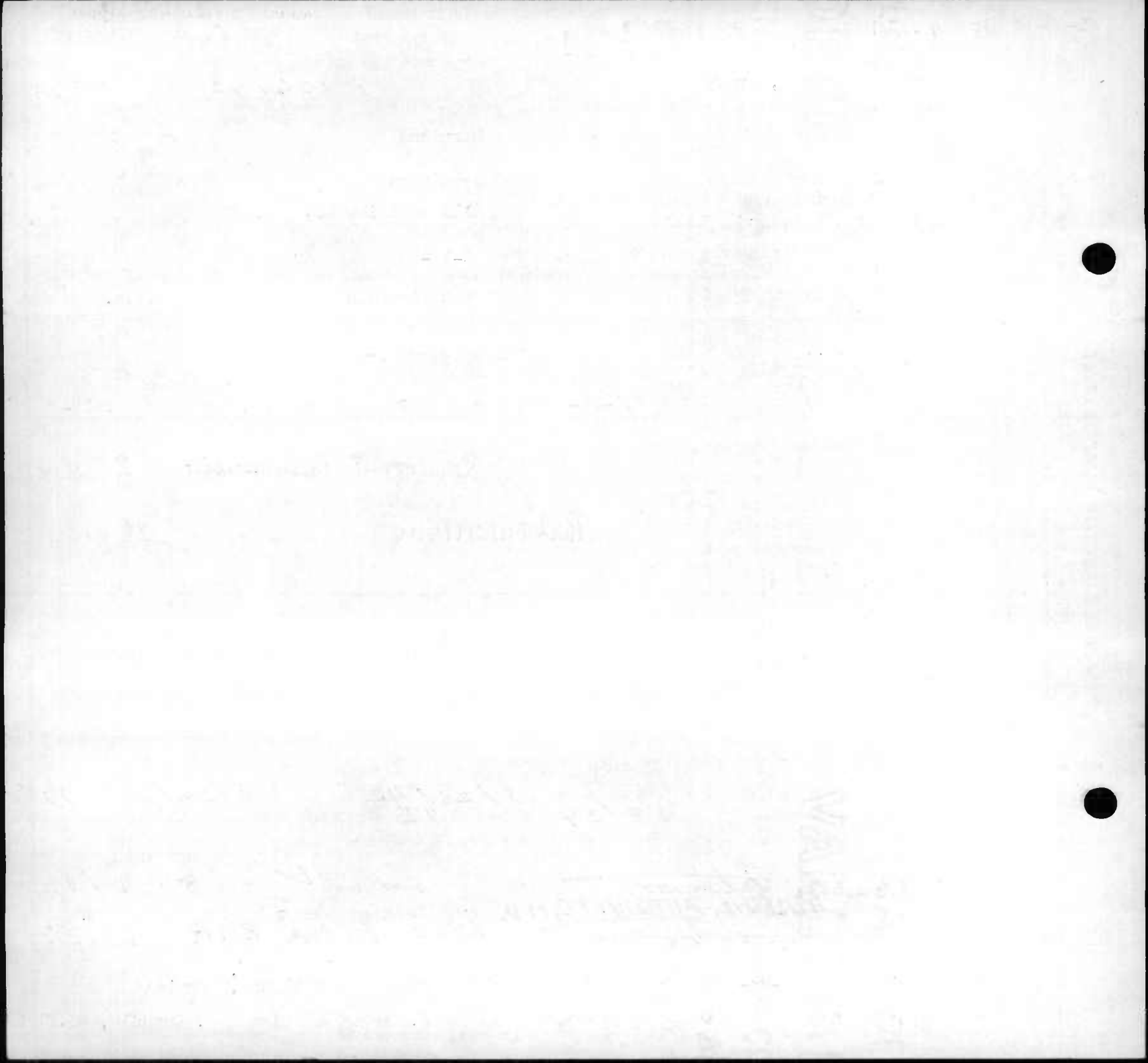


49-00-12 djr

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 08242		72 08242	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.		STATE OF MARYLAND - DEPT.	
Keffer, Ivory		8/24/72 6:08 AM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-16-04	
9. AGE (In years last birthday) 68		10. AGE (In years last birthday) 68		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Williams		14. MOTHER'S MAIDEN NAME Margaret Lester		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 233-07-2030D	
17. INFORMANT BCH: RECORDS Baltimore, Maryland 21224		ADDRESS 4940 Eastern Avenue		17. INFORMANT BCH: RECORDS Baltimore, Maryland 21224		ADDRESS 4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 342X I ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Recurrent Pneumonia (B) Parkinsonism DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 days 26 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/23/72 19 to 8/24/72 1972, that (I) (we) last saw the deceased alive on 8/24 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE HIROSHI MITSUMOTO, M.D.		23B. DATE SIGNED 8/24/72		23C. PHYSICIAN'S NAME (Type) HIROSHI MITSUMOTO, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-28-72		24C. NAME of CEMETERY or CREMATORY Holly Hill Memorial Gardens		24D. LOCATION (City, town, or county) (State) White Marsh, Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 29 1972		25B. NAME OF REGISTRAR Sidney Whitson		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222	



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YS 150-REV. 1/1/68

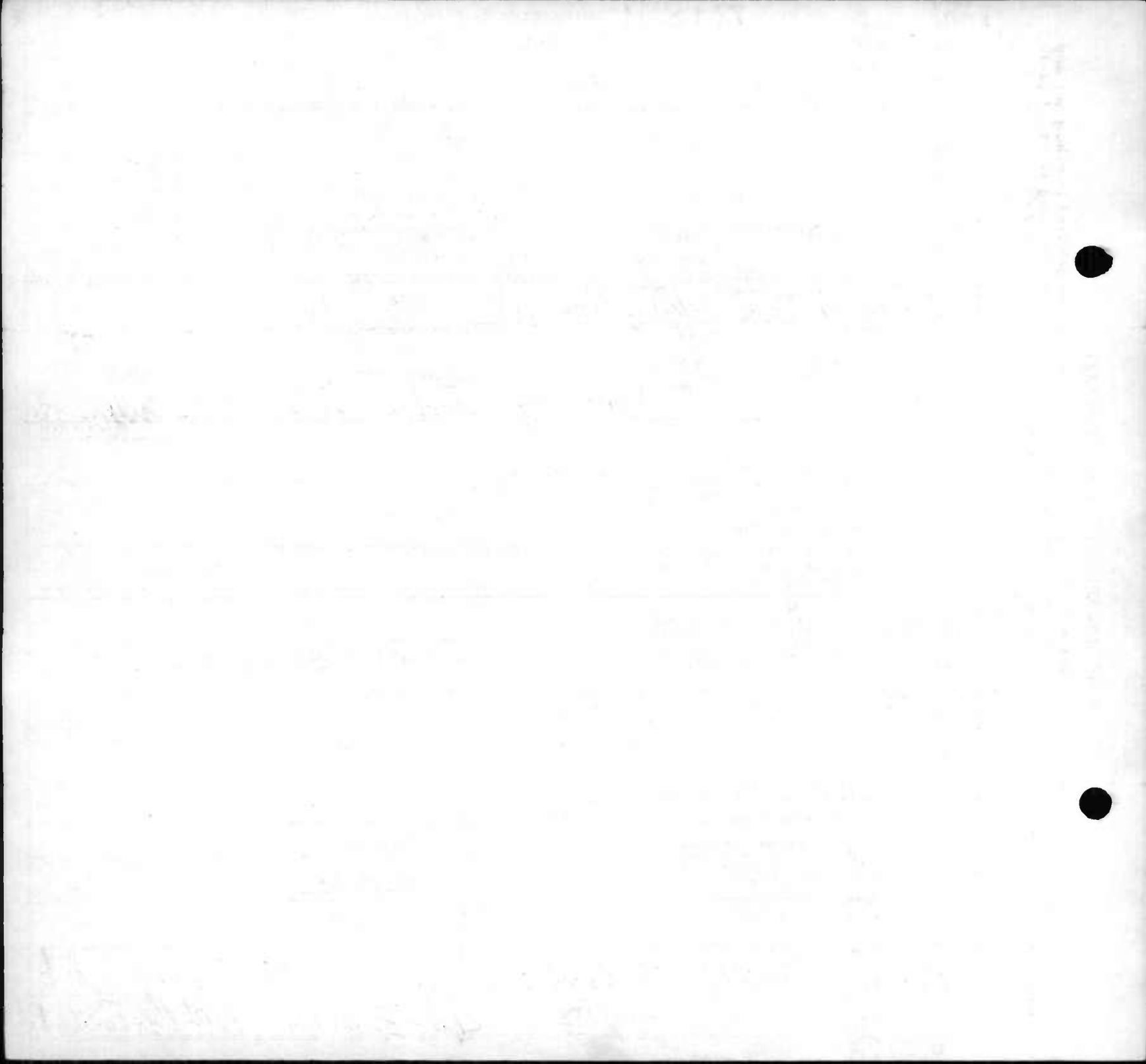


# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
C-520				STATE OF MARYLAND-DEME	
BIRTH NO.				CHANCE WILLIAM H.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
CHANCE, WILLIAM H.				8-25-72 8.32 pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
Union Memorial Hospital, Baltimore M.D.				Baltimore M.D. U.S.A.	
44				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				3825 White Ave, Baltimore M.D.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days: Hours: Min.
M	white		4-4-83	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Steamfitter			Heating Power Co.		State Md
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
John Chance			SARAH TARBOTTON		U.S.A
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			207-05-8968		Evelyn Hartig 8222 Oakleigh Rd
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest.	
ANTECEDENT CAUSES				The hospital because of CVA and developed	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: Rheumatoid arthritis in the	
				hospital that was treated.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 8-7-1972 to 8-25-1972 that (2) (we) last saw the deceased alive on 8-25-1972 and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. YAZDANI				8-25-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MAHIN YAZDANI				UNION MEMORIAL HOSPITAL Baltimore M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		8/30/72		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 29 1972		[Signature]		GARY EVANS JR 8802 HARTOED RD	





G-650

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 72-07188

1. NAME OF DECEASED (Type or Print) Nickie Christine Grimm		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 24 72 4:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 24 72 4:45 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN BALTIMORE	
9. DATE OF BIRTH 5-18-1972		10. AGE (In years last birthday) 3 6 1	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		15. MOTHER'S MAIDEN NAME Maria P. Lang	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. George F.P. Grimm, 5229 Benson Ave. 21227		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Sudden death in infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Marvin S. Platt</i> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-26-1972	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 29 1972		25B. NAME OF REGISTRAR <i>Adrienne Houston</i>	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

1930 S.

MEMORANDUM FOR THE RECORD

1

TO: THE CHIEF OF BUREAU

FROM: THE CHIEF OF BUREAU

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

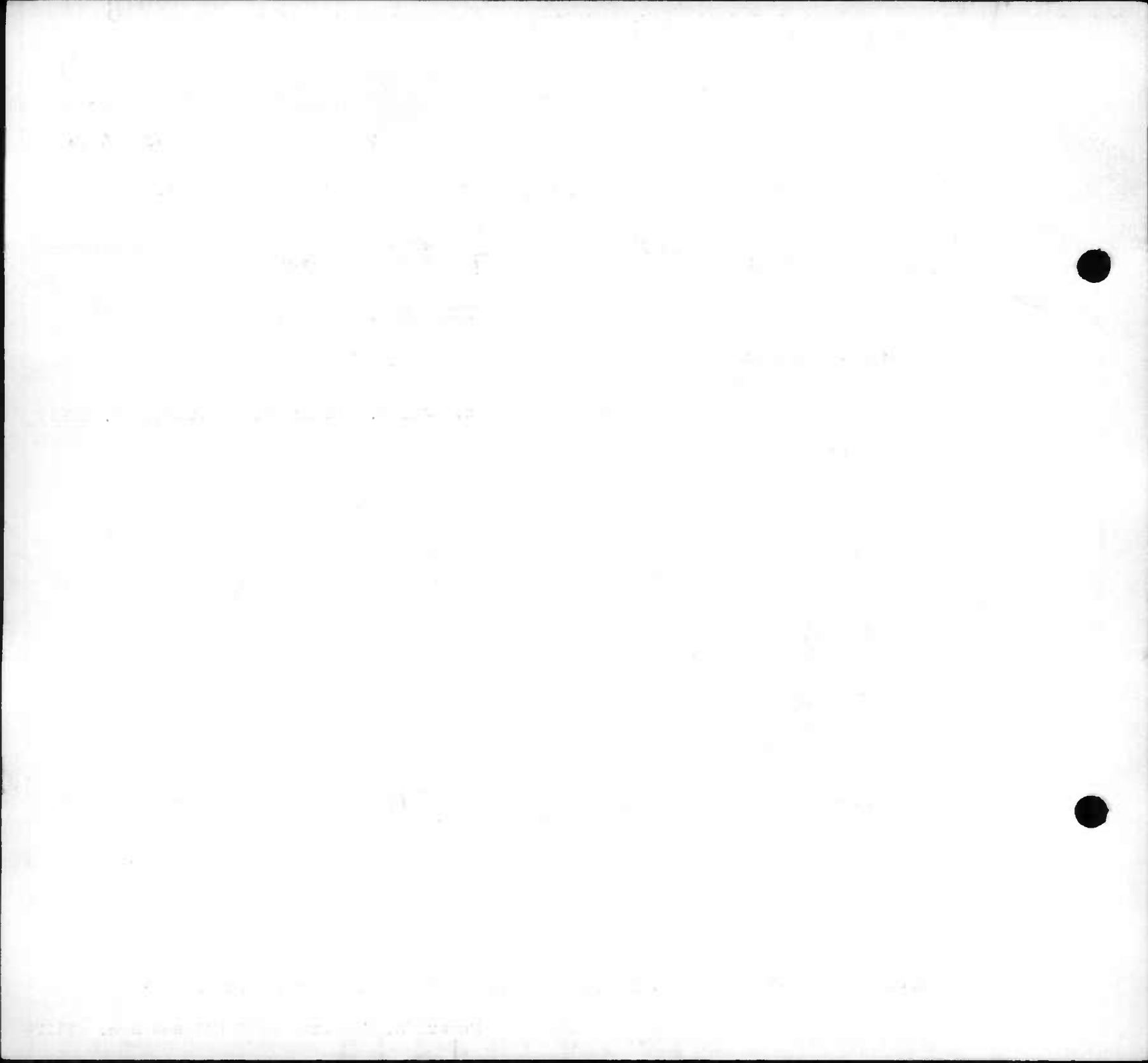
23. [Illegible]

24. [Illegible]

25. [Illegible]

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BALTIMORE CITY HEALTH DEPARTMENT 72 08246 CERTIFICATE OF DEATH				REG. NO. 72 08246	
BIRTH NO. S-560		1. NAME OF DECEASED (Type or Print) CHARLES F. SIEMER		2. DATE AND HOUR OF DEATH August 24, 1972 8:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL 43 HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1206 Carroll St.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/5/99	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgetown Maryland	
13. FATHER'S NAME William Siemer			14. MOTHER'S MAIDEN NAME (Unknown)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-1388		17. INFORMANT ADDRESS Mr. Carl G. Siemer, 1227 Carroll St. 21230	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 431.91 CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest - (B) DUE TO, OR AS A CONSEQUENCE OF: Increase intracranial pressure - (C) Cerebral hemorrhage - 5 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 19 1972 to August 24 1972 that (I) (we) last saw the deceased alive on August 24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert C. Feliciano DEGREE			23B. DATE SIGNED August 24/72		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 8-28-1972		24C. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery
24D. LOCATION (City, town, or county) Baltimore, Maryland			24E. STATE (State) Maryland		
25A. DATE REC'D BY HEALTH DEPT AUG 29 1972		25B. NAME OF REGISTRAR Sidney Whorton		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

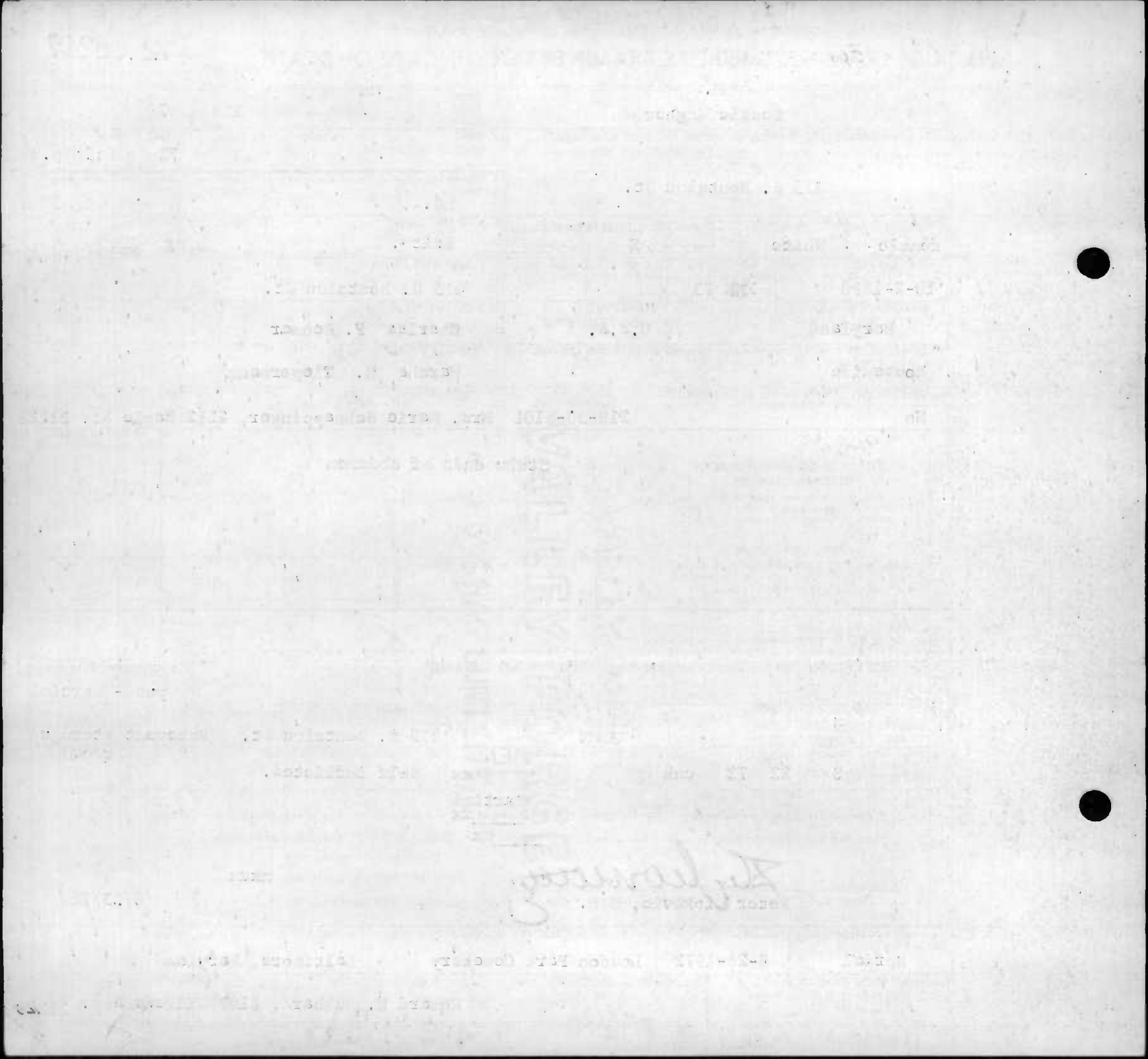


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Bessie Wagner</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>8</b> Day <b>22</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>415 S. Bentalou St.</b>		3. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>22</b> Year <b>72</b> Hour <b>6:30 p.</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2005</b>			
6. SEX <b>female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b>
9. DATE OF BIRTH <b>10-7-1898</b>		10. AGE (In years last birthday) <b>73</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	E. STREET AND NUMBER <b>415 S. Bentalou St.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	13. FATHER'S NAME <b>Charles F. Benner</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-30-6101</b>	15. MOTHER'S MAIDEN NAME <b>Martha M. Tiepermann</b>
18. INFORMANT <b>Mrs. Marie Schnappinger, 2212 Eagle St. 21223</b>		ADDRESS	
19. <b>E956X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Stabwounds of abdomen</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>CAUSE OF DEATH</b> <b>Stabwounds of abdomen</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>	
22D. TIME OF INJURY (APPROX.) Month <b>8</b> Day <b>22</b> Year <b>72</b> Hour <b>unk.</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>415 S. Bentalou St. (Basement storage room)</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Self inflicted.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> XXX ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/23/72</b>	
ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-26-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitson</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		ADDRESS	





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

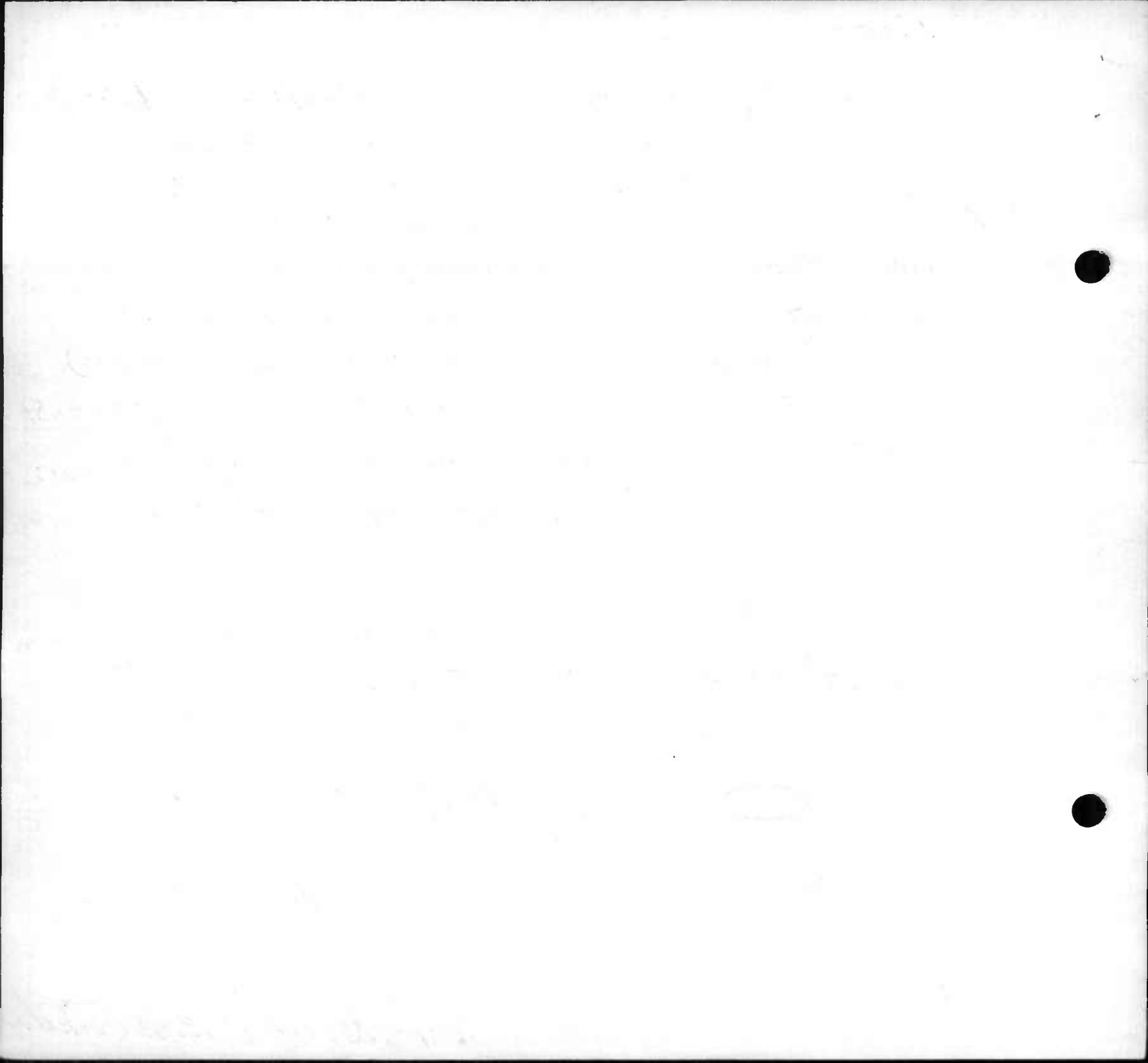
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08248</b>	
H-460 72 08248				STATE OF MARYLAND - DHMH	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Hiller, Katherine E.</b>				2. DATE AND HOUR OF DEATH <b>8/25/72 6:50 am</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>40 St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland,</b> B. COUNTY <b>2005</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2649 Wilkens Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/11/83</b>	9. AGE (In years lost birthday) <b>89</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Michael Murphy</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Broderick</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-05-0168B</b>		17. INFORMANT ADDRESS <b>Mrs. Alice Clifton, 2649 Wilkens Ave. 21223</b>
18. CAUSE OF DEATH <b>412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>19A. DATE OF OPERATION</b> <b>0</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY? (Yes or No)</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b> <b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b> <b>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> <b>21F. HOW DID INJURY OCCUR?</b> <b>22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> <b>23A. SIGNATURE</b> <b>23B. DATE SIGNED</b> <b>23C. PHYSICIAN'S NAME (Type)</b> <b>23D. ADDRESS</b> <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>24B. DATE</b> <b>24C. NAME OF CEMETERY or CREMATORY</b> <b>24D. LOCATION (City, town, or county) (State)</b> <b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>25B. NAME OF REGISTRAR</b> <b>25C. FUNERAL DIRECTOR ADDRESS</b>					
Burial			8-28-1972		New Cathedral Cemetery
Baltimore, Maryland			Howard H. Hubbard, 4107 Wilkens Ave. 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		BALTIMORE CITY HEALTH DEPARTMENT		72 08249
BIRTH NO.		72 08249		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.
Elizabeth Graham		8/26/72		6:45 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY		
Montebello State Hospital 91		Maryland Baltimore 843		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Fem	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)
House wife		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
Icoac Graham		Marta Wilson (Douglas)		16. SOCIAL SECURITY NO.
17. INFORMANT		ADDRESS		
Sarah Jones		2702 East Preston St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
162.11		Squamous cell carcinoma of		2 years.
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES		the left lung with metastasis.		(B) DUE TO, OR AS A CONSEQUENCE OF:
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		(D) DUE TO, OR AS A CONSEQUENCE OF:
II		Paraplegia sec metastasis T4.		2 months
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
Feb 1971		Left upper lobectomy		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 8/8/72 to 8/26/72 that (I) (we) last saw the deceased alive on 8/26/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)
Changyale MD		8/26/72		23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
BURIAL		8/31/72		Mt. Auburn
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
AUG 29 1972		Lindsey Houston		Joseph J. Rock 1304 N. Central



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 08250		BIRTH NO.	
CERTIFICATE OF DEATH				Emitt		REG. NO. 72 08250	
STATE OF MARYLAND - DEPT. OF HEALTH				1716 PM		Aug 24, 1972	
1. NAME OF DECEASED (Type or Print) <b>EMMETT HOLT</b>				2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>909</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1404 E. LANVALE ST.</b>							
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-12-05</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Atlanta Ga.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOHN HOLT</b>				14. MOTHER'S MAIDEN NAME <b>Queen</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>256-09-2452</b>		17. INFORMANT <b>Charlie Burns 1404 E. Lanvale St.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 min</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinoma of the Lung</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>3 mos.</b>			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 22</b> 19 <b>72</b> to <b>Aug 24</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Aug 24</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Bruce K. Lloyd MD</b>				23B. DATE SIGNED <b>Aug 24, 1972</b>			
23C. PHYSICIAN'S NAME (Type) <b>BRUCE K. LLOYD MD</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8/29/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Int. Calvary Cem</b>		24D. LOCATION (City, town, or county) (State) <b>G. A. County, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Andrew H. Hinton</b>		25C. FUNERAL DIRECTOR <b>Joseph J. Locks</b>		ADDRESS <b>1504 N. Central St.</b>	

T. 2.

1-10-1

T. 2.

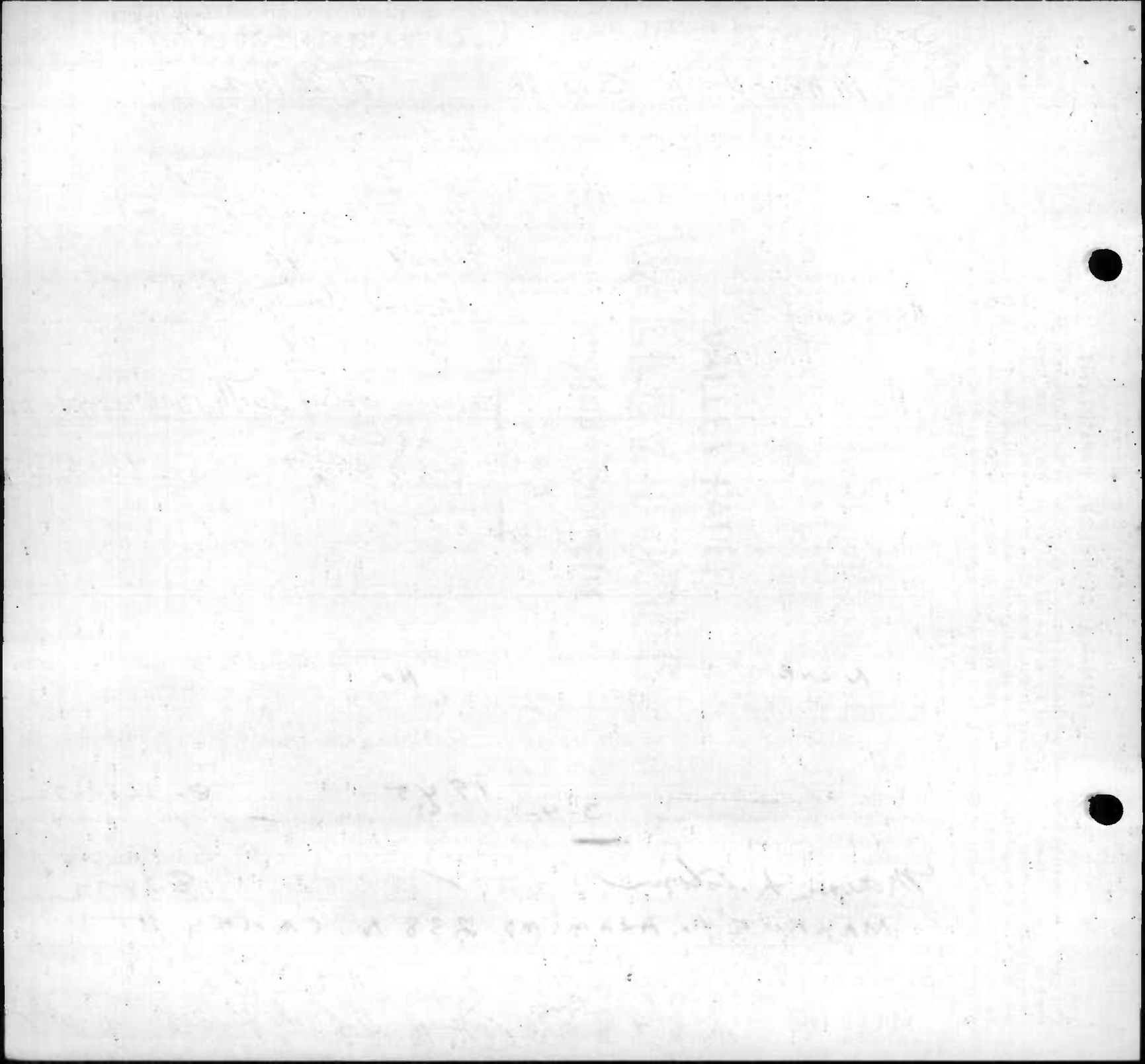


# FUNERAL DIRECTOR: IMPORTANT

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S-530		72 08251		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 08251	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARIAN L. SMITH</b>		2. DATE AND HOUR OF DEATH <b>8/26/72</b>		STATE OF MARYLAND - DISTRICT			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>806</b>		5. SEX <b>F</b>		6. RACE <b>C N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>1719 E. LAFAYETTE AVE.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>1719 E. LAFAYETTE ST AVE</b>		B. DATE OF BIRTH <b>9/1/81</b>		9. AGE (In years last birthday) <b>90</b>		If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Harford County, Md</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Thomas</b>		14. MOTHER'S MAIDEN NAME <b>?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RAYMOND MELVIN SMITH</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>250.91</b>		CAUSE OF DEATH <b>ASCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>44RS</b>					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>DIA BETRS</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>DIA BETRS</b>							
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1945</b> to <b>8-26-1972</b> that (I) (we) last saw the deceased alive on <b>3-4-1969</b> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Maurice L. Adams</b>		23B. PHYSICIAN'S NAME (Type) <b>MAURICE L. ADAMS MD</b>		23C. ADDRESS <b>238 N. CANNERY ST</b>		23D. DATE SIGNED <b>8-28-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/30/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. County. Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Lidney Whitson</b>		25C. FUNERAL DIRECTOR <b>Joseph J. Locks</b>		ADDRESS <b>1304 N. Central Ave</b>			

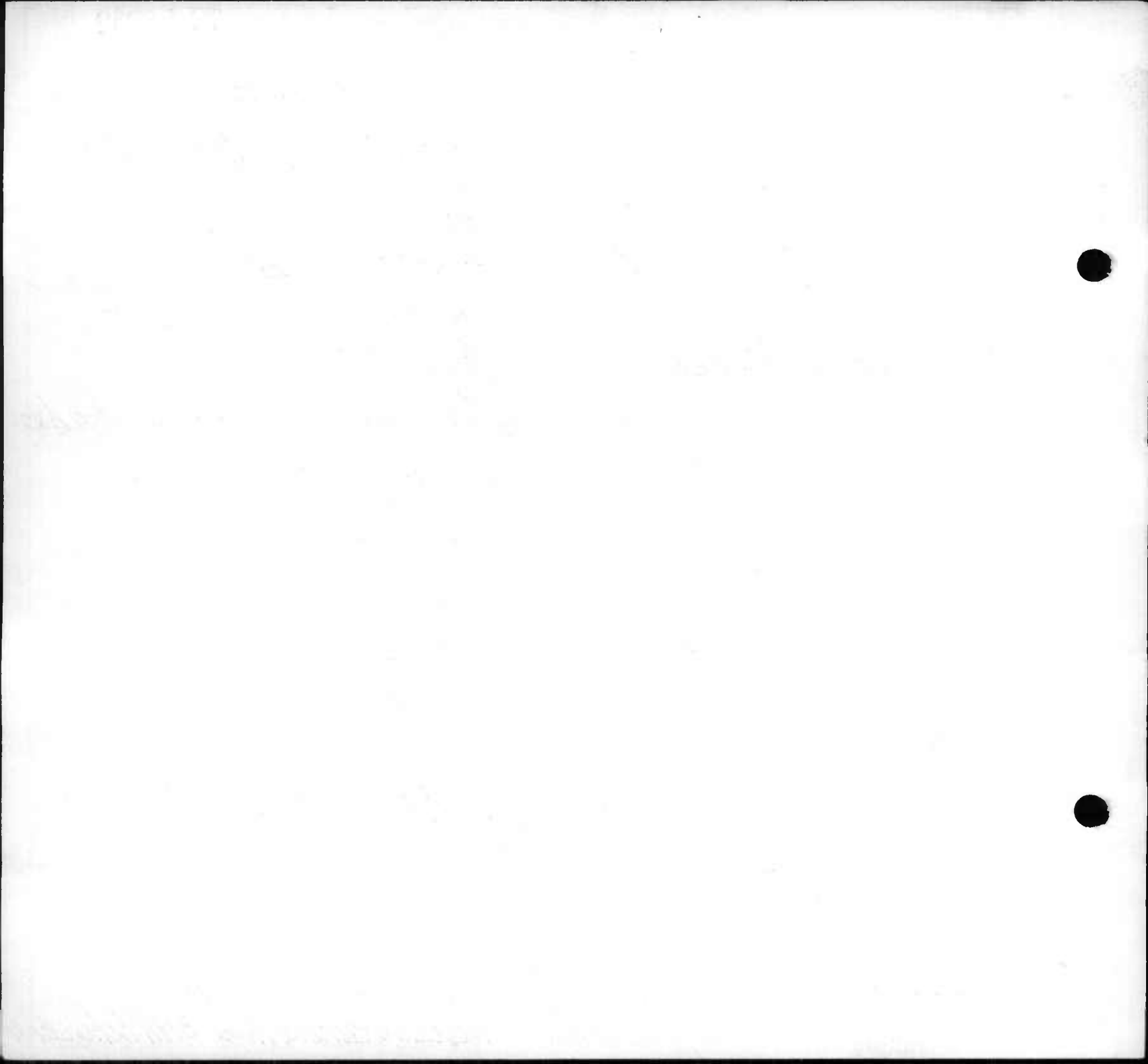




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620		72 08252		BALTIMORE CITY HEALTH DEPARTMENT		72 08252	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Brooks, Annie</i>				2. DATE AND HOUR OF DEATH <i>8-24-72 8:10 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Univ. of Md. Hosp.</i>				A. STATE B. COUNTY <i>808 W. Lexington St. Apt 3</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS? <i>Balto., Md.</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>808 W. Lexington St.</i>				1801			
5. SEX <i>F</i>	6. RACE <i>B</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-1-07</i>	9. AGE in years (last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NA</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Newberry S.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Chess Booker</i>				14. MOTHER'S MAIDEN NAME <i>Annie</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-09-8905</i>		17. INFORMANT ADDRESS <i>Cdc/Wicker 633 Pumperton Ave.</i>			
18. <i>410.91</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>myocardial infarction</i>			
ANTECEDENT CAUSES				(B) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>01/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-20</i> 19 <i>72</i> to <i>8-24</i> 19 <i>72</i> and that (I) (we) lost saw the deceased alive on <i>8-24</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John D. Hughes MD</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>John Hughes MD</i>				23D. ADDRESS <i>Univ. of Md. Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/28/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto. National Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Audrey Thornton</i>		25C. FUNERAL DIRECTOR <i>Williams Funeral Home</i>		ADDRESS <i>3191 Schrock St</i>	



R-140

72 08253

STATE OF MARYLAND - DEMO

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08253

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MILTON C. RAFAEL, JR.</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 22 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland General Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 22 72 2:46 p.</b> M.	
6. SEX <b>male</b>		7. RACE <b>White</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>11/18/41</b>		10. AGE (In years last birthday) <b>30</b>		E. STREET AND NUMBER <b>6115 Fairdale Road</b>	
11. BIRTHPLACE (State or foreign country) <b>New Orleans, La.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Milton C. Rafael, Sr.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Bar</b>		15. MOTHER'S MAIDEN NAME <b>Stella Mariano</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Milton C. Rafael, Sr. 2348 Plaza Dr. Chalmers, La.</b>	
19. <b>E965X1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>BLDG.</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1038 N. Calvert Street 1101</b>	
22D. TIME OF INJURY (APPROX.) <b>8 22 72 unk</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject was shot.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		DATE SIGNED <b>8/23/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/26/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Louis Cem. #3</b>	
24D. LOCATION (City, town, or county) (State) <b>New Orleans, La.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>			
25B. NAME OF REGISTRAR <b>Frederick D. Miller, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3019 E. Monument St.</b>			

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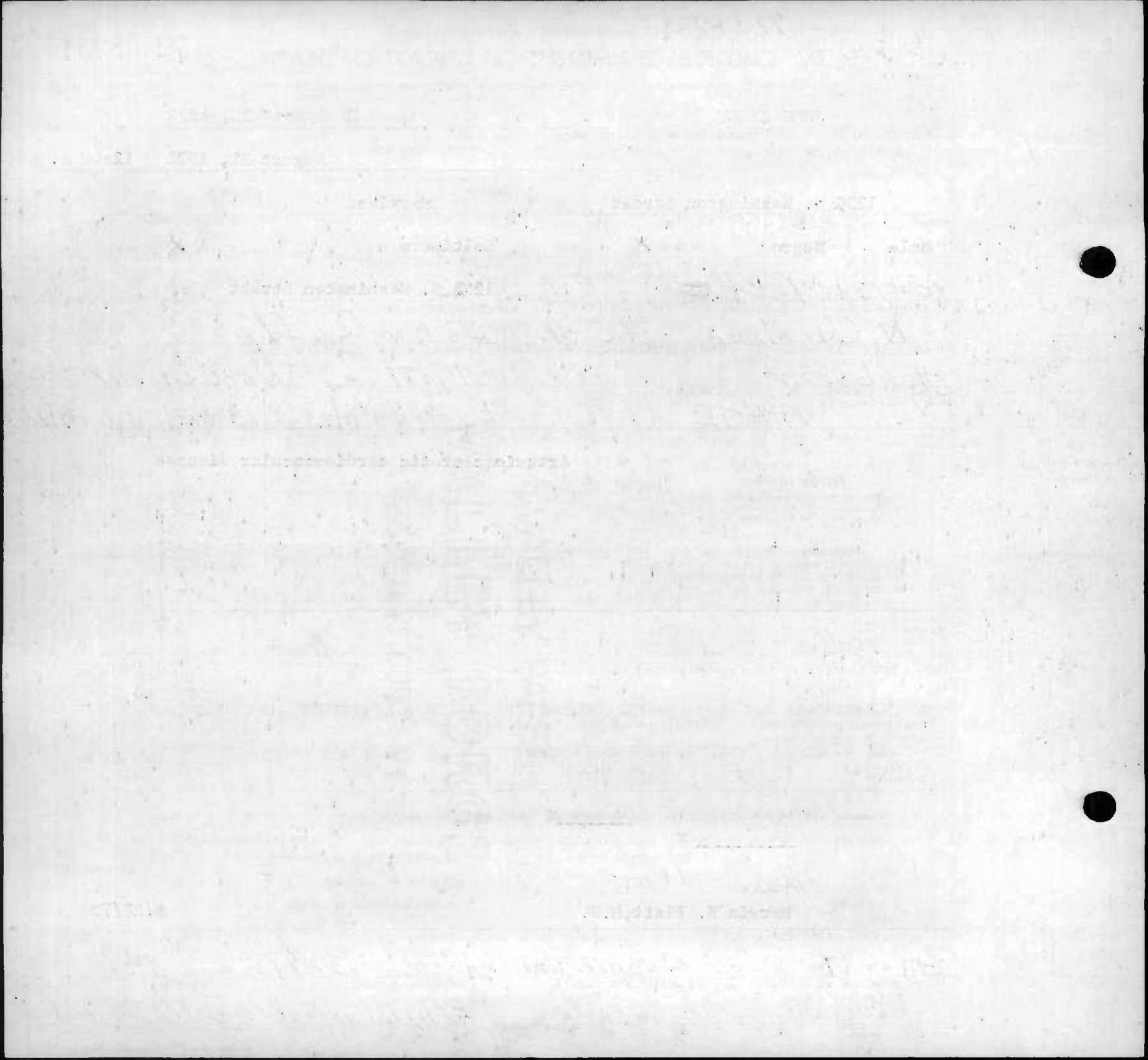
G-300

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN GADDY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> <b>August 22, 1972</b>		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1232 N. Washington Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 22, 1972 12:00 A.</b>		M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>808</b>				
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>10-13-07 64</b>		10. AGE (In years lost birthday) <b>64</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		E. STREET AND NUMBER <b>1232 N. Washington Street</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>John Gaddy</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.II</b>		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME <b>Mittie Woodburn</b>
18. INFORMANT <b>Evelyn Miles</b>		ADDRESS <b>873 Washington Blvd.</b>		
19. <b>412-4</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> DATE SIGNED <b>8/22/72</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-25-72</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTO. NATIONAL Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>BALTO. Md.</b>		24E. FUNERAL DIRECTOR <b>Elliott Funeral Home</b>		24F. ADDRESS <b>1129 N. Caroline St.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney B. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Elliott Funeral Home</b>





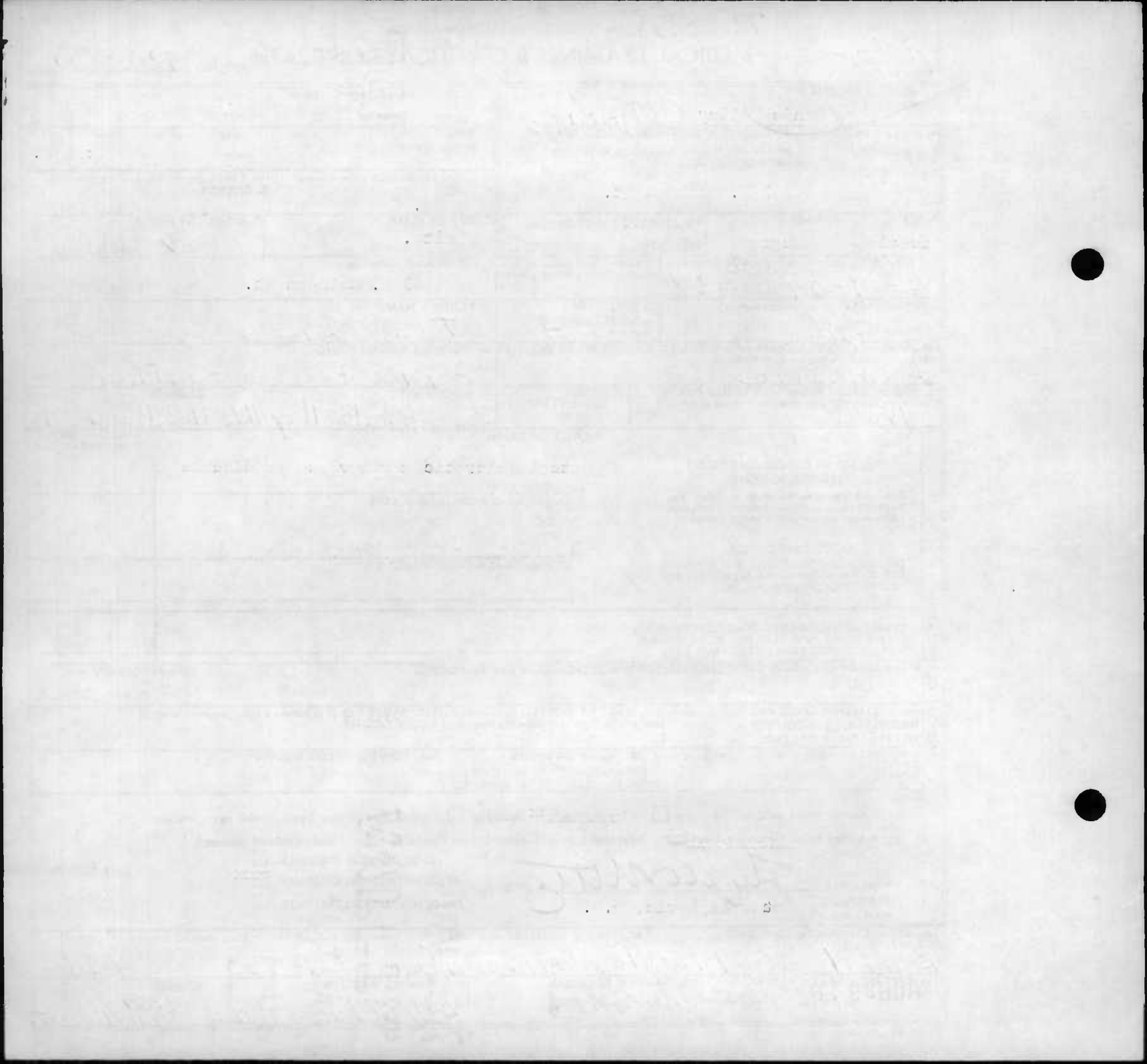
72 08255 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08255

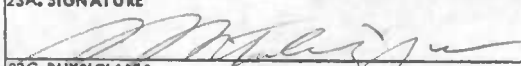
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Annie Holley (MARIE)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 8 Day 23 Year 72 Hour M. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1143 N. Calhoun St.		3. DATE PRONOUNCED DEAD Month 8 Day 23 Year 72 Hour 10:55 a. M.	
6. SEX female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1602	
9. DATE OF BIRTH 6-9-04		10. AGE (In years last birthday) 68	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Annie Frances Gunther		16. INFORMANT ADDRESS Joseph F. Holley 1143 N. Calhoun St.	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/23/72 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-29-72	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 29 1972		25B. NAME OF REGISTRAR Sidney Whorton	
25C. FUNERAL DIRECTOR		ADDRESS Elliott Funeral Home 1129 N. Caroline St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-600		72 08256		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08256	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEME			
1. NAME OF DECEASED (Type or Print) <b>CHARLES CURRY, W.</b>				2. DATE AND HOUR OF DEATH <b>1 Pm 8/18/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>S.B.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>B. COUNTY</b> <b>HARBOUR VIEW NURSING HOME</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>43 S. BALTIMORE GENERAL HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1213 LIGHT ST.</b>		<b>704</b>	
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16-25-1897</b>		9. AGE (in years last birthday) <b>74</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>? VIRGINIA</b>	
13. FATHER'S NAME <b>? UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>? UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-10-2051</b>		17. INFORMANT <b>Emma Lee Moore</b>	
				ADDRESS <b>952 N. WASHINGTON</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>162.1 I</b> [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] <b>TERMINAL PNEUMONIA</b> <b>BRONCHOPNEUMONIA</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHOPNEUMONIA</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>GENERALISED CA</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/13</b> 19 <b>72</b> to <b>8/19</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>8/19</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED <b>8/19/72</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. CARLOS N. PATALINGHUG</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>8/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. County Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Adrienne Houston</b>	
25C. FUNERAL DIRECTOR <b>ELLIOTT FUNERAL HOME</b>				ADDRESS <b>1129 N. CALHOUN ST.</b>			

6/5/69

0-3-1

952 N. Washington, St

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-632		72 08257		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08257	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Louis B. Murdock</b>			
2. DATE AND HOUR OF DEATH <b>8/22/72 2:25</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>				C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>3418 Mondawmin Ave</b>							
5. SEX <b>Masc</b>		6. RACE <b>N.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01/27/98</b>	
9. AGE (In years last birthday) <b>74</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Alabama. Alabama</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>Alfred Murdock</b>				14. MOTHER'S MAIDEN NAME <b>Louise Williams</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218102866A</b>		17. INFORMANT <b>Alfred M. Murdock</b>	
ADDRESS <b>3210 Lake Av.</b>							
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <b>Myocardial Infarct</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Heart Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Generalized Arteriosclerosis</b>				years years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>0</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>an.</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>8/22/1.35 1972</b> to <b>8/22/2.25 1972</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. Gonzalez CMD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/22/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Cesar L. Gonzalez C.</b>				23D. ADDRESS <b>1015 Halstead Rd. Ap. 2</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-25-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Garden of Eternal Hope</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Andrey M. Brown</b>		25C. FUNERAL DIRECTOR <b>Ellen H. Fagerall Home</b>			
ADDRESS <b>1129 N. Caroline St</b>							

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## FUNERAL DIRECTOR: IMPORTANT

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T-260		72 08258		BALTIMORE CITY HEALTH DEPARTMENT		72 08258	
BIRTH NO.		72 08258		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		GENEVA TUCKER		2. DATE AND HOUR OF DEATH		8/22/72 11:05 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md.		843	
Good Samaritan Hosp.		45		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		B		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7/15/12	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Food service		Food service		Lawrenceville, VA		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
James (Tucker) Jeffress		HARRIS, Estelle		No		92-4-2007	
17. INFORMANT		ADDRESS		17. INFORMANT		ADDRESS	
Ruth BANKS		1212 Edison Highway		Ruth BANKS		1212 Edison Highway	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Chronic renal failure		2yr.	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Chronic pyelonephritis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Hypertensive Cardiovascular disease					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/9/72 to 8/22/72		that (I) (we) last saw the deceased alive on 8/22/72		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED		23C. ADDRESS			
Timothy D. Carnes MD		8/22/72		Good Samaritan Hospital			
23D. PHYSICIAN'S NAME (Type)		23E. ADDRESS		23F. ADDRESS			
TIMOTHY D. CARNES MD		Good Samaritan Hospital		1129 N. Caroline St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION	
Burial		8-26-72		Baltimore Cemetery		Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 29 1972		Audrey H. Hinton		Edith Funeral Home		1129 N. Caroline St	



Burial 8-26-52 Baltimore Cemetery Baltimore, Md.

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GENEVA TUCKER

8-25-52

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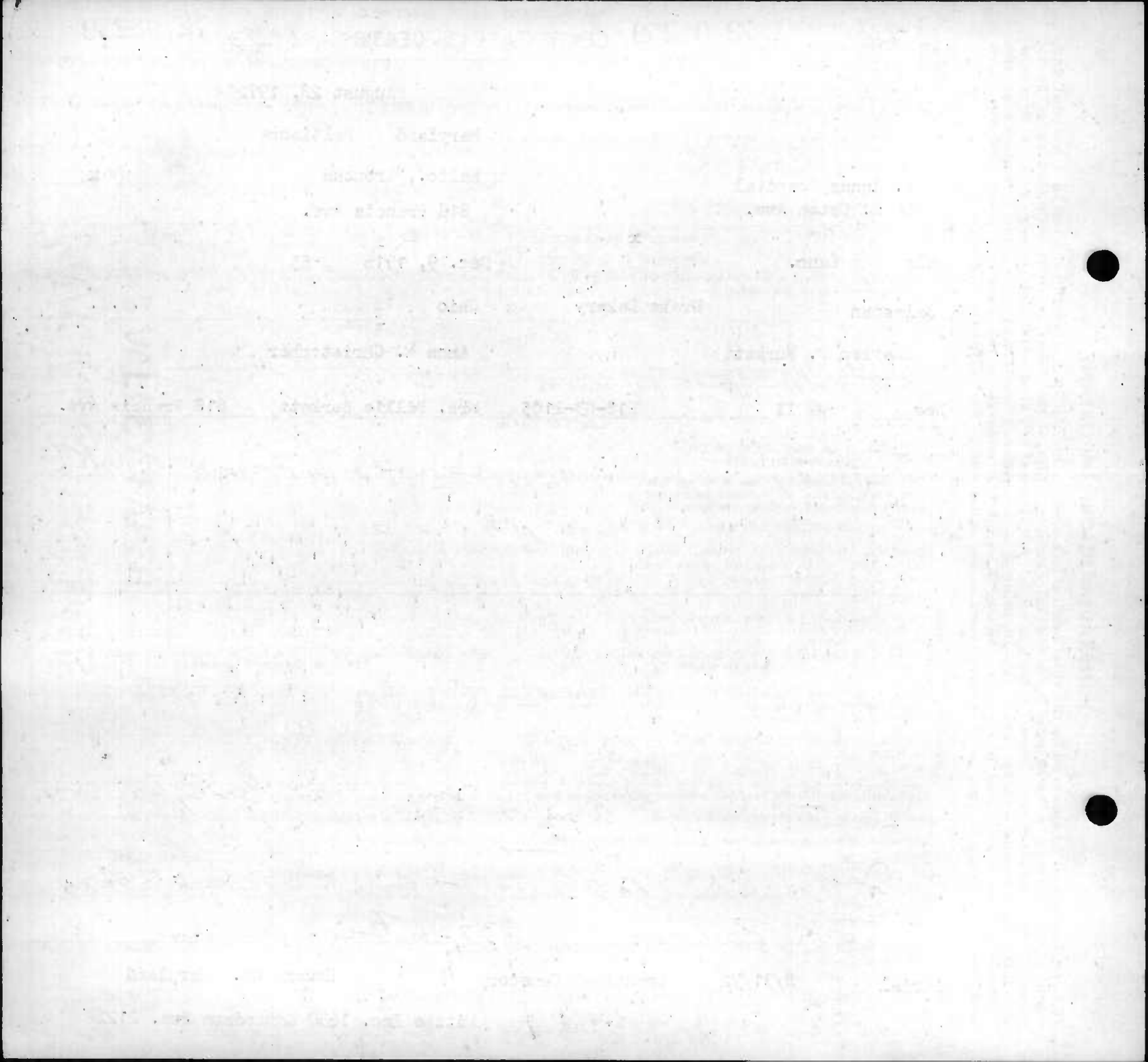
T-860

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FUNERAL DIRECTOR: IMPORTANT

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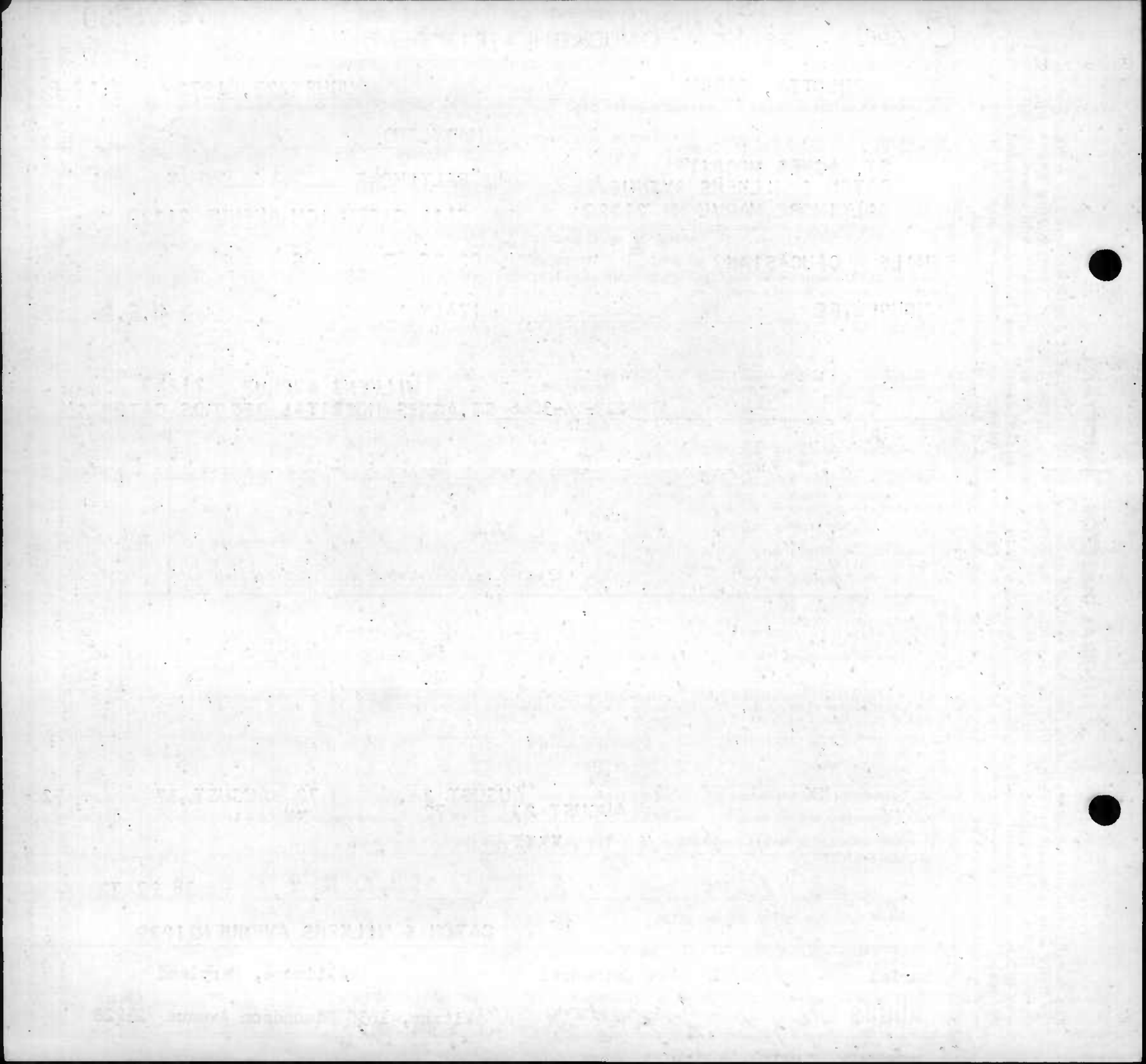
BALTIMORE CITY HEALTH DEPARTMENT		72 08259		72 08259	
B-623		72 08259		72 08259	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JACK F. BURKETT</b>		2. DATE AND HOUR OF DEATH <b>August 28, 1972</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital</b> <b>900 S. Caton Ave.</b>		C. CITY OR TOWN <b>Balto., Arbutus</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>818 Francis Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1916</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Drake Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Charles F. Burkett</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Christopher</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-03-2105</b>		17. INFORMANT <b>Mrs. Billie Burkett</b>	
<b>WW II</b>		<b>818 Francis Ave.</b>		ADDRESS	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>AS.C.V.D</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1962</b> to <b>Aug 28 1972</b> , that (I) (we) last saw the deceased alive on <b>Aug 7 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. C. Pound</b>		23B. DATE SIGNED <b>8/28/72</b>		23C. PHYSICIAN'S NAME (Type) <b>J. C. Pound</b>	
23D. ADDRESS <b>3325 Fendrich Ave</b>		23E. DEGREE <b>DEGREE</b>		23F. DEGREE <b>DEGREE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/31/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Crestlawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Howard Co. Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		24F. NAME OF REGISTRAR <b>Adrian J. J. J.</b>	
24G. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		24H. NAME OF REGISTRAR <b>Adrian J. J. J.</b>		24I. FUNERAL DIRECTOR <b>Witzke Inc.</b>	
24J. ADDRESS <b>1630 Edmondson Ave.</b>		24K. ADDRESS <b>21228</b>		24L. ADDRESS <b>21228</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT 72 08260 C-430				REG. NO. 72 08260 STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) <b>CULOTTA, SARAJE</b>			2. DATE AND HOUR OF DEATH <b>AUGUST 27, 1972 7:15 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL CATON &amp; WILKENS AVENUE BALTIMORE MARYLAND 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2854</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5112 GREENWICH AVENUE 21229</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02 25 87</b>	9. AGE (In years lost birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>213-74-3066</b>		17. INFORMANT ADDRESS <b>WILKENS AVENUE 21229 ST. AGNES HOSPITAL RECORDS CATON &amp;</b>
18. <b>427.31 + 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Respiratory failure + 5 days</b> (B) <b>C.V.A.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>+ 6 days</b> (C) <b>pacemaker insertion for complete A.V. block + 10 days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes mellitus</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>AUGUST 2</b> 19 <b>72</b> to <b>AUGUST 27</b> 19 <b>72</b> , that <b>(X)</b> (we) lost saw the deceased alive on <b>AUGUST 27</b> 19 <b>72</b> and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) <b>(X)</b> view the body after death.					
23A. SIGNATURE <b>JJ Mol</b>				23B. DATE SIGNED <b>08 27 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JJ Mol</b>				23D. ADDRESS <b>CATON &amp; WILKENS AVENUE N21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/30/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>			
25B. NAME OF REGISTRAR <b>Louise Witzke</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 1630 Edmondson Avenue 21228</b>			



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08261</u>	
5-690 72 08261				STATE OF MARYLAND-DEMD	
BIRTH NO.				2864	
1. NAME OF DECEASED (Type or Print) <b>Harry R. Sherk</b>			2. DATE AND HOUR OF DEATH <b>8/26/72 8:30</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Caton Manor Nursing Center</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2864</b>		
5. SEX <b>Male</b>			6. RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>7/31/90</b>		
9. AGE (In years last birthday) <b>82</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			16. SOCIAL SECURITY NO. <b>213-10-4315</b>		
17. INFORMANT <b>Mr. Dorsey Baldwin, 4917 Westhills Road 21229</b>			ADDRESS		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>cardiac arrhythmia</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic myo-carditis &amp; failure</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Advanced pulmonary emphysema</b>					
19. DATE OF OPERATION <b>0</b>					
20. AUTOPSY? (Yes or No) <b>No</b>					
21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
22. I certify that (I) (this hospital) attended the deceased from <b>June 1972</b> to <b>8/26</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>8/26</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William J. Bryson MD</b>					
23B. DATE SIGNED <b>8/28/72</b>					
23C. PHYSICIAN'S NAME (Type) <b>Dr. Wm. J. Bryson</b>					
23D. ADDRESS <b>Westview Mall</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
24B. DATE <b>8/29/72</b>					
24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>					
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>					
25B. NAME OF REGISTRAR <b>Witzke, 11630 Edmondson Avenue 21228</b>					
25C. FUNERAL DIRECTOR ADDRESS					







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
B-400 72 08262 CERTIFICATE OF DEATH					REG. NO. 72 08262					
STATE OF MARYLAND-DEM										
1. NAME OF DECEASED (Type or Print) <b>BILLY, NATHANIEL</b>					2. DATE AND HOUR OF DEATH <b>8-23-72 9:45 AM</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>PENNSYLVANIA</b> B. COUNTY <b>✓ 35</b> C. CITY OR TOWN <b>PITTSBURGH</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>115 MAYWOOD STREET</b>					
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-32</b>	9. AGE (In years last birthday) <b>40</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME <b>NATHANIEL BILLY</b>					14. MOTHER'S MAIDEN NAME <b>BESSIE</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>220 30 2501</b>		17. INFORMANT <b>Precious Billy</b>			ADDRESS <b>5126 Levindale St.</b>		
18. <b>157.8 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE Cardiovascular collapse</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) METASTATIC Brain disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) excision of mt of pancreas</b> <b>1 year</b>										
19. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>none</b>										
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>July 27</b> 19 <b>72</b> to <b>Aug 23</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Aug 23</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>F. M. WIGLEY</b>					23B. DATE SIGNED <b>8/23/72</b>					
23C. PHYSICIAN'S NAME (Type) <b>F. M. WIGLEY M.D.</b>					23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/25/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY CEMETERY</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 29 1972</b>			25B. NAME OF REGISTRAR <b>James Johnston</b>			25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT FUNERAL HOME</b>			ADDRESS <b>1701 Laurens St</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08263	
R-120 67-14373 08263				REG. NO.	
BIRTH NO.				STATE OF MARYLAND	
1. NAME OF DECEASED (Type or Print) <u>Rufus, Lamonte McCray</u>			2. DATE AND HOUR OF DEATH <u>8-24-72</u> <u>8:45</u> (P.M.)		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University of Md. Hospital</u> <u>Dept of Ped.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1503</u>		
5. SEX <u>M</u>			6. RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>7-7-67</u>
13. FATHER'S NAME <u>Charles Rufus</u>			14. MOTHER'S MAIDEN NAME <u>MARY A. McCray</u>		9. AGE (In years last birthday) <u>4 yrs.</u> If Under 1 Yr. Months: Days: Hours: Min.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>1801 M</u>		17. INFORMANT <u>mother</u>
18. <u>481X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Lobar Pneumonia and Pseudomonas UTI</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Myasthenia gravis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-22-72</u> 19 <u>72</u> to <u>8-24</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>8-24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Faye Eaton, M.D.</u>			23B. DATE SIGNED <u>8-24-72 10PM</u>		23C. PHYSICIAN'S NAME (Type) <u>Faye Eaton, M.D.</u>
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8-29-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 29 1972</u>			25B. NAME OF REGISTRAR <u>Andrew H. Heston</u>		25C. FUNERAL DIRECTOR <u>Robert Dyett F.H. 1701-1701</u>

12/23/71

1801 MORELAND AVE. 21216

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08264

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Emmett Lewis				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 24 72 4:30 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 24 72 4:30 P.M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-31-34				10. AGE (in years lost birthday) 38		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Emmett Lewis		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 381	
15. MOTHER'S MAIDEN NAME Myrtle Lewis				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Delores Lewis				19. ADDRESS 235 Mason			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Subdural hematoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) Yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown			
22C. WHERE DID IT IN BALTIMORE CITY, GIVE EXACT LOCATION) INJURY OCCUR? Unknown				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Unknown			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR? Unknown			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE: William P. Mulloy, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 8-25-72							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-29-72		24C. NAME OF CEMETERY or CREMATORY MT. CALVERY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. AUG 29 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR MORTON & DYETT F. H.		25D. ADDRESS 1701 LAURENS ST.	

8/17/72

235 Mason Ct.

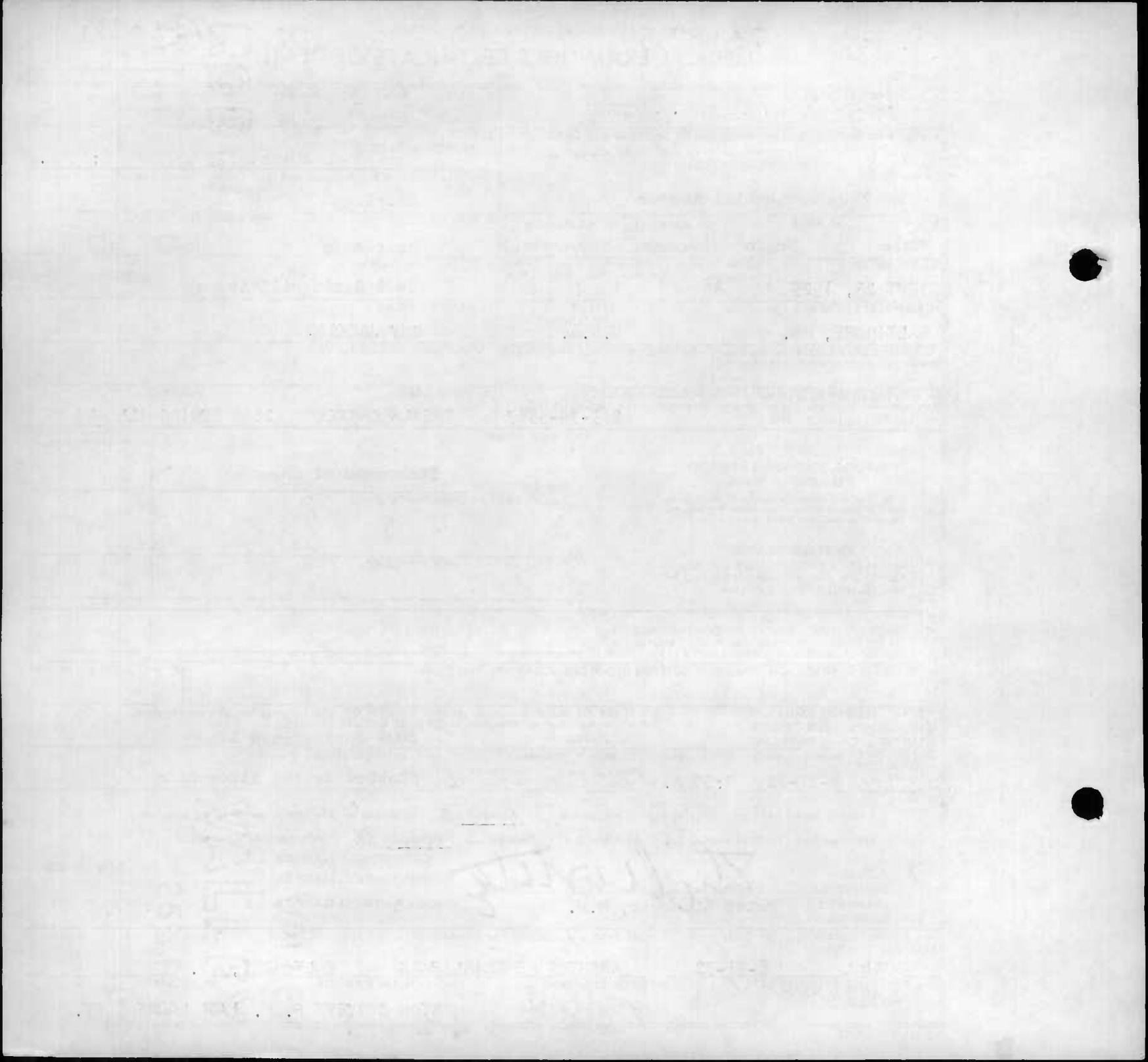
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ELVERSON G. JACKSON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>August</b> Day <b>27</b> Year <b>1972</b> Hour _____ M. _____	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>2604 Springhill Avenue</b>		3. DATE PRONOUNCED DEAD Month <b>August</b> Day <b>27</b> Year <b>1972</b> Hour <b>2:51 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1512</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>SEPT 23, 1925</b>	10. AGE (In years lost birthday) <b>46</b>	If Under 1 Yr. If Under 24 Hrs. Months _____ Days _____ Hours _____ Min. _____	E. STREET AND NUMBER <b>2604 Springhill Avenue</b>
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>GUY JACKSON</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>213-34-9567</b>	18. INFORMANT <b>SHEILA CARTER</b> ADDRESS <b>2604 SPRINGHILL AVENUE</b>
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Stabwound of chest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>8-27-72 2:30 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2604 Springhill Avenue</b>		22F. HOW DID INJURY OCCUR? <b>Stabbed during altercation</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 27, 1972</b> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>8-31-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS MEMORIAL PARK</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>James H. Hoston</b>	25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F. H. 1701 LAURENS ST.</b>





# FUNERAL DIRECTOR: IMPORTANT

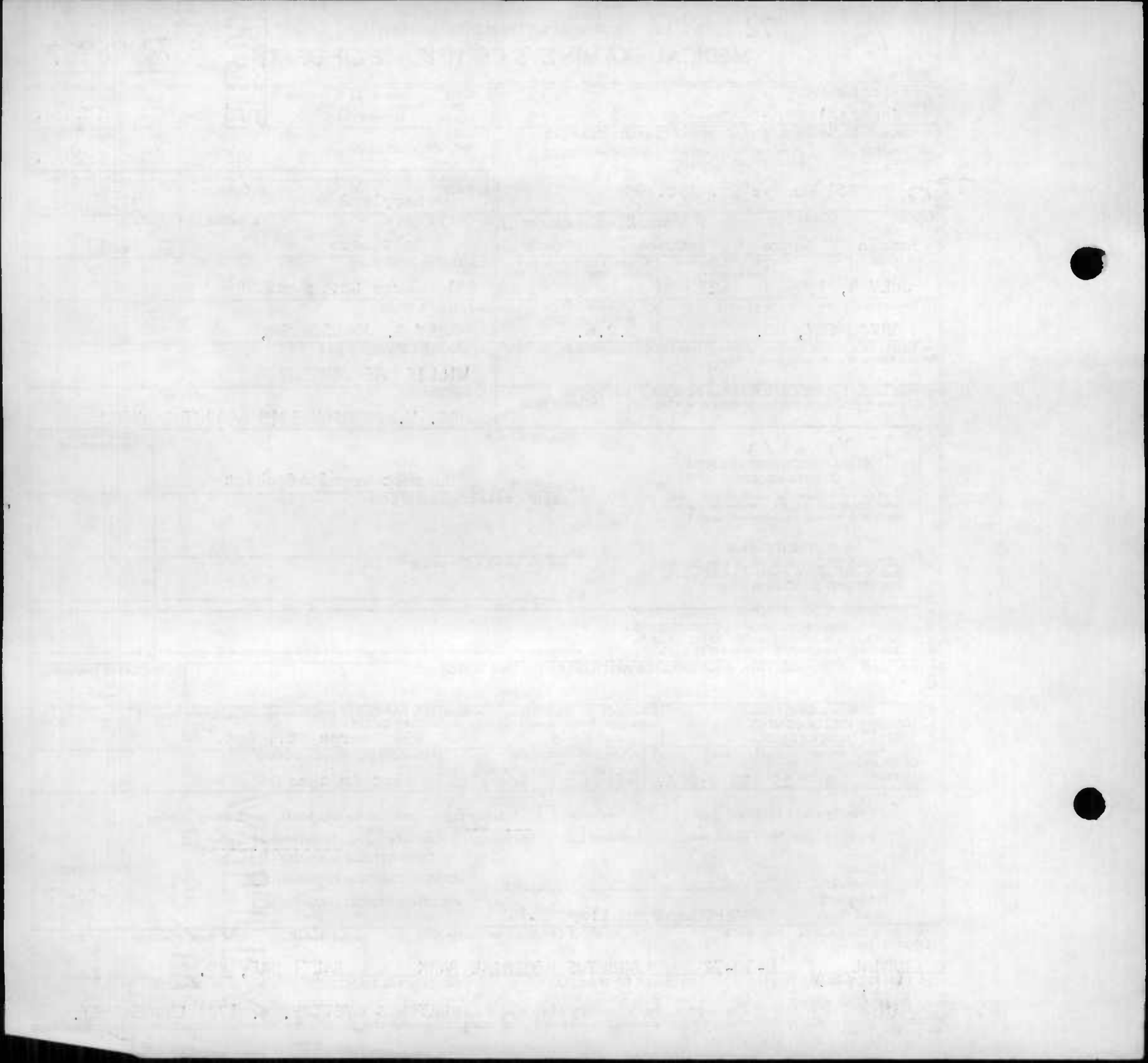
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-520		72 08266		BALTIMORE CITY HEALTH DEPARTMENT		72 08266	
<b>CERTIFICATE OF DEATH</b>				REG. NO. <b>STATE OF MARYLAND-DHMH</b>			
1. NAME OF DECEASED (Type or Print) <b>Finch, Fannie Mae</b>				2. DATE AND HOUR OF DEATH <b>8/25-72</b> <b>501</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Johns Hopkins Hospital</b> <b>601 N Broadway Balt. 21205</b>				A. STATE <b>MD</b> <b>Baltimore</b> <b>2802</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4408 ETLAND</b>			
5. SEX <b>F</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-25-25</b>	9. AGE (In years last birthday) <b>46</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Durham, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Bunny Osmond</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Edger</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Relmer Finch - 4408 ETLAND Ave.</b>			
18. <b>174X I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Terminal Carcinoma of breast 13 years</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>8/22-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>percutaneous cordotomy</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/21</b> 19 <b>72</b> to <b>8/25</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/25</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>21 25 pm</b>							
23A. SIGNATURE <b>Sumio Uematsu M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8/25-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SUMIO UEMATSU M.D.</b>				23D. ADDRESS <b>601 N. Broadway Balt.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8-29-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Carver Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Kauvel, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Audrey Johnston</b>		25C. FUNERAL DIRECTOR <b>Robert D. F. H.</b>		ADDRESS <b>1701-Kauvel St</b>	

**AUG 29 1972**

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P-400		72 08267		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		72 08267		REG. NO.	
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) <b>(CLORIE) Glorie Powell</b>						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 25 72 2:20 A.M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>851 George St. Apt. 90</b>						3. DATE PRONOUNCED DEAD Month Day Year Hour 8 25 72 2:20 A.M.					
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1703</b>						C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>851 George St., Apt. 90</b>					
9. DATE OF BIRTH <b>JULY 4, 1945</b>		10. AGE (In years last birthday) <b>27</b>		11. BIRTHPLACE (State or foreign country) <b>MONTGOMERY, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HARRY B. JOHNSON SR.</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>WILLIE MAE JOHNSON</b>					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>MRS. W. JOHNSON 5019 AARBUTUS AVENUE</b>					
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes											
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>851 George St., Apt. 90</b>			
22D. TIME OF INJURY (APPROX.) 8 25 72 2:00A.m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>shot in chest</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <b>William P. Mulloy</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8-25-72</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>											
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-30-72</b>		24C. NAME of CEMETERY or CREMATORY <b>ARBUTUS MEMORIAL PARK</b>				24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>				25B. NAME OF REGISTRAR <b>Sidney B. Johnson</b>				25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F. H. 1701 LAURENS ST.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-400		72 08268		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08268	
BIRTH NO.				STATE OF MARYLAND-DEPT			
1. NAME OF DECEASED (Type or Print) <b>NOLLEY, GEORGE ALBERT</b>				2. DATE AND HOUR OF DEATH <b>August 23, 1972 5:25 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH <b>2/17/03</b>		9. AGE (In years last birthday) <b>69</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>				11. BIRTHPLACE (State or foreign country) <b>LAWRENCEVILLE, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>BAIL S. NOLLEY</b>				14. MOTHER'S MAIDEN NAME <b>ORA CLAIBORNE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 3/1/62 to 2/26/65</b>				16. SOCIAL SECURITY NO. <b>215 05 65 02</b>		17. INFORMANT ADDRESS <b>Medical Records VA Hospital, Baltimore, Md. 21218</b>	
18. <b>410.9 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b>				<b>MINUTES</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>				<b>YEARS</b>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NONE</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 4</b> 19 <b>72</b> to <b>August 23</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>August 23</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Meyer R. Heyman M.D.</i> DEGREE						23B. DATE SIGNED <b>8-23-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MEYER R. HEYMAN, M. D.</b> DEGREE				23D. ADDRESS <b>VA Hospital, Baltimore, Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8-28-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <i>Sidney Houston</i>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H.</b>		ADDRESS <b>1701 LAURENS ST.</b>	





B-650

72 08269

STATE OF MARYLAND - DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08269

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM H. BROWN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 23, 1972</b>		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 23, 1972</b>		Hour <b>6:13 P. M.</b>
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>4-28-38</b>		10. AGE (In years lost birthday) <b>34</b>		11. BIRTHPLACE (State or foreign country) <b>ST. STEVENS, S. C.</b>
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>MOSES BROWN</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE VANCE</b>
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WHITE HOUSE</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO.
18. INFORMANT <b>MOSES BROWN</b>		19. ADDRESS <b>823 J STREET SPARROWS PT.</b>		
19. CAUSE OF DEATH <b>Severe pulmonary congestion and</b> (A) IMMEDIATE CAUSE <b>hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebro-cranial injuries</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2-8-72</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No) <b>Yes</b>				
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>warehouse</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Parthen &amp; McHenry (Schapiro &amp; Whitehouse Inc.)</b>
22D. TIME OF INJURY (APPROX.) <b>3-11-72 ?</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Fell down stairs</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> DATE SIGNED <b>August 24, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-28-72</b>		24C. NAME of CEMETERY or CREMATORY <b>MT. AUBURN CEMETERY</b>
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Whitman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F. H. 1701 LAURENS ST.</b>

10-12-1972 - Completion of cause of death on a Pending Medical Examiner Death Certificate  
Marvin S. Platt, M.D. HS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08270	
C-200 72 08270				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>CHASE, JAMES ARTHUR</b>			2. DATE AND HOUR OF DEATH <b>August 23, 1972 5:00 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.</b> <b>Baltimore, Md. 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore,</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1129 Argyle Ave.</b>		
5. SEX <b>Male</b>	6. RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-27-15</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland, BALTIMORE</b>	
13. FATHER'S NAME <b>JOHN CHASE</b>			14. MOTHER'S MAIDEN NAME <b>LILLIE CHASE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 11-12-42 to 2-8-46</b>		16. SOCIAL SECURITY NO. <b>215-01-9453</b>		17. INFORMANT <b>Records V. A. Hospital</b> ADDRESS <b>3900 Loch Raven Blvd., Baltimore, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>I</b> <b>150X</b> <b>INTRACTABLE SHOCK</b> <b>SEPSIS 2° BREAKDOWN MEDIASTINUM COLON</b> <b>ADVANCED CARCINOMA ESOPHAGUS</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>5 days</b> <b>3 weeks</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ESOPHAGEAL CARCINOMA</b>					
19A. DATE OF OPERATION <b>8/18/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ESOPHAGEAL CARCINOMA</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 4,</b> 19 <b>72</b> to <b>August 23,</b> 19 <b>72</b> , that <b>XX</b> (we) last saw the deceased alive on <b>August 23,</b> 19 <b>72</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <b>XX</b> view the body after death.					
23A. SIGNATURE <b>W. SINDELAR, M.D.</b>				23B. DATE SIGNED <b>August 24, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>W. SINDELAR, M.D.</b>		23D. ADDRESS <b>VA Hospital</b> <b>Baltimore, Md 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-28-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GETTSBURG, NATIONAL CEMETERY</b>	
24D. LOCATION <b>GETTSBURG, PENN.</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F. H.</b> ADDRESS <b>1701 LAURENS ST.</b>	

WASHINGTON, D. C.

DECEMBER 1, 1944

TO THE CHIEF

FROM THE DIRECTOR

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 08271</span>	
W-356 <span style="font-size: 1.2em;">72 08271</span>				STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">William R. Whitmarsh</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">8-27-72</span> <span style="float: right;">4 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.1em;">Md.</span> B. COUNTY <span style="font-size: 1.1em;">2759</span>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.1em;">1304 Argonne Drive</span>			C. CITY OR TOWN <span style="font-size: 1.1em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <span style="font-size: 1.1em;">1304 Argonne Drive 21218</span>		
5. SEX <span style="font-size: 1.1em;">M</span>	6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">2-17-1889</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">83</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Ret. Salesman</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">Gulf Oil Co.</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Gelatt, Pa.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.1em;">George Whitmarsh</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Sue Gelatt</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">yes WW I</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">179-03-3560</span>	17. INFORMANT ADDRESS <span style="font-size: 1.1em;">Mrs. William R. Whitmarsh Same</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="font-size: 1.1em;">Ruptured aortic abdominal aneurism</span> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.1em;">Arteriosclerosis</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">Sudden</span> <span style="font-size: 1.1em;">Many years</span>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.1em;">None</span>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">no</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <del>(Medical Examiner)</del> attended the deceased from <span style="font-size: 1.1em;">about 1940</span> 19 <span style="font-size: 1.1em;">Aug. 21, 1972</span> to <span style="font-size: 1.1em;">Aug. 27, 1972</span> 19 <span style="font-size: 1.1em;">Aug. 27, 1972</span> and that (I) <del>(Medical Examiner)</del> last saw the deceased alive on <span style="font-size: 1.1em;">Aug. 21, 1972</span> 19 <span style="font-size: 1.1em;">Aug. 27, 1972</span> and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(Medical Examiner)</del> view the body after death.					
23A. SIGNATURE <span style="font-size: 1.1em;">R. B. Wright M. D.</span>			23B. DATE SIGNED <span style="font-size: 1.1em;">Aug. 28, 1972</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">R. B. Wright M. D.</span>			23D. ADDRESS <span style="font-size: 1.1em;">313 Medical Arts Bldg.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>	24B. DATE <span style="font-size: 1.1em;">8-30-72</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Moreland Mem. Park</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Co. Maryland</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">AUG 29 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Sidney H. Jenkins</span>	25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">H. W. Jenkins Sons Co. 4905 York Rd. Baltimore, Maryland 21212</span>		

1940

1941

1942

1943

1944

1945

1946

1947

1948



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES DEAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1138 N. Gilmore St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 27 1972 11:20 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>8-11-28</b>		10. AGE (In years lost birthday) <b>44</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Mattie</b>		13. FATHER'S NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Bertha Dean</b>		ADDRESS <b>3506 Virginia Ave.</b>	
19. CAUSE OF DEATH <b>Stabwounds of chest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>in front of 1140 N. Gilmore St.</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>8-27-72 11:15 p.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Stabbed by unknown assailant.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8-28-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-28-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>		ADDRESS <b>1348 Caloun Street</b>	



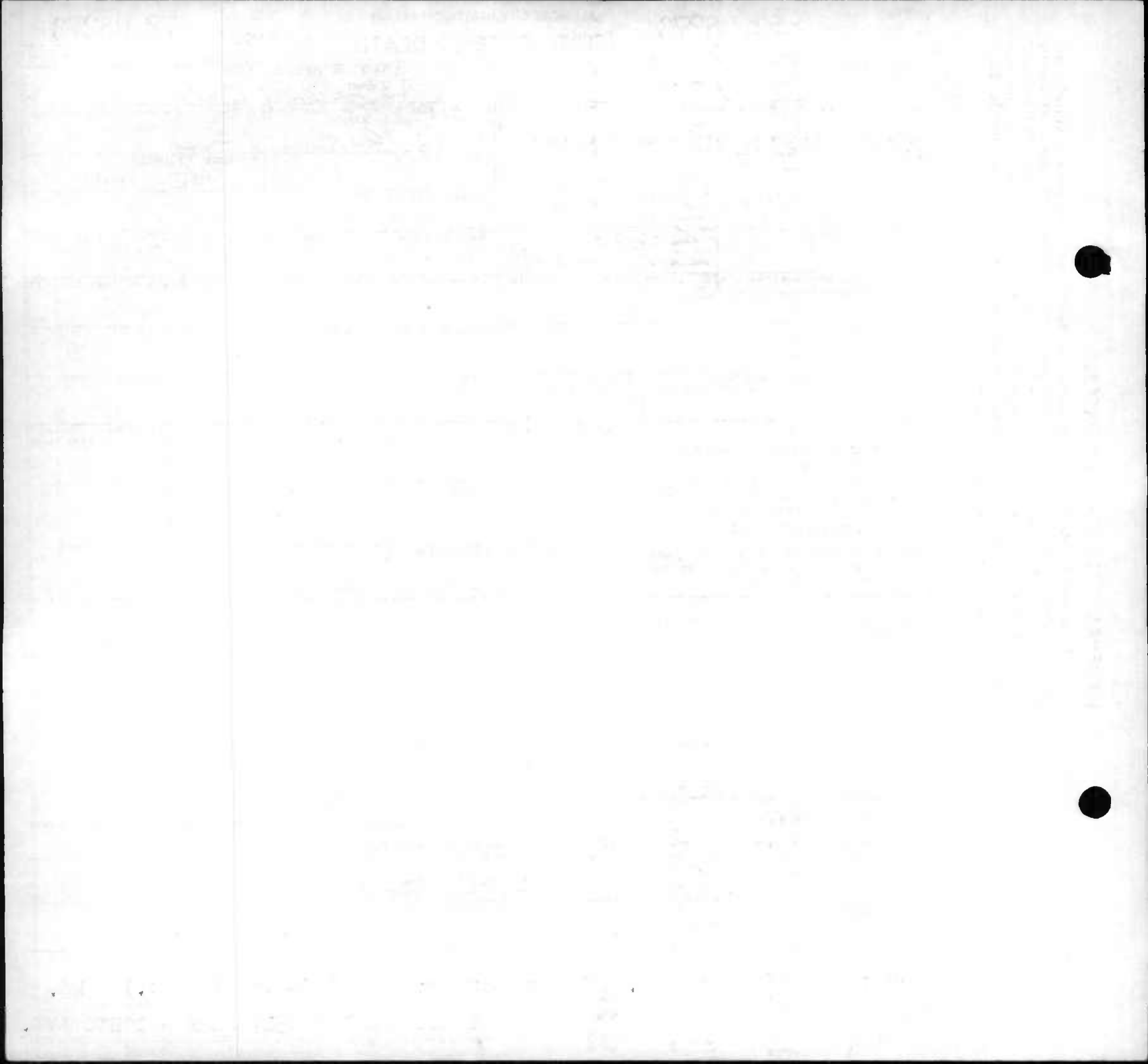
55-0110

WALLLEY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

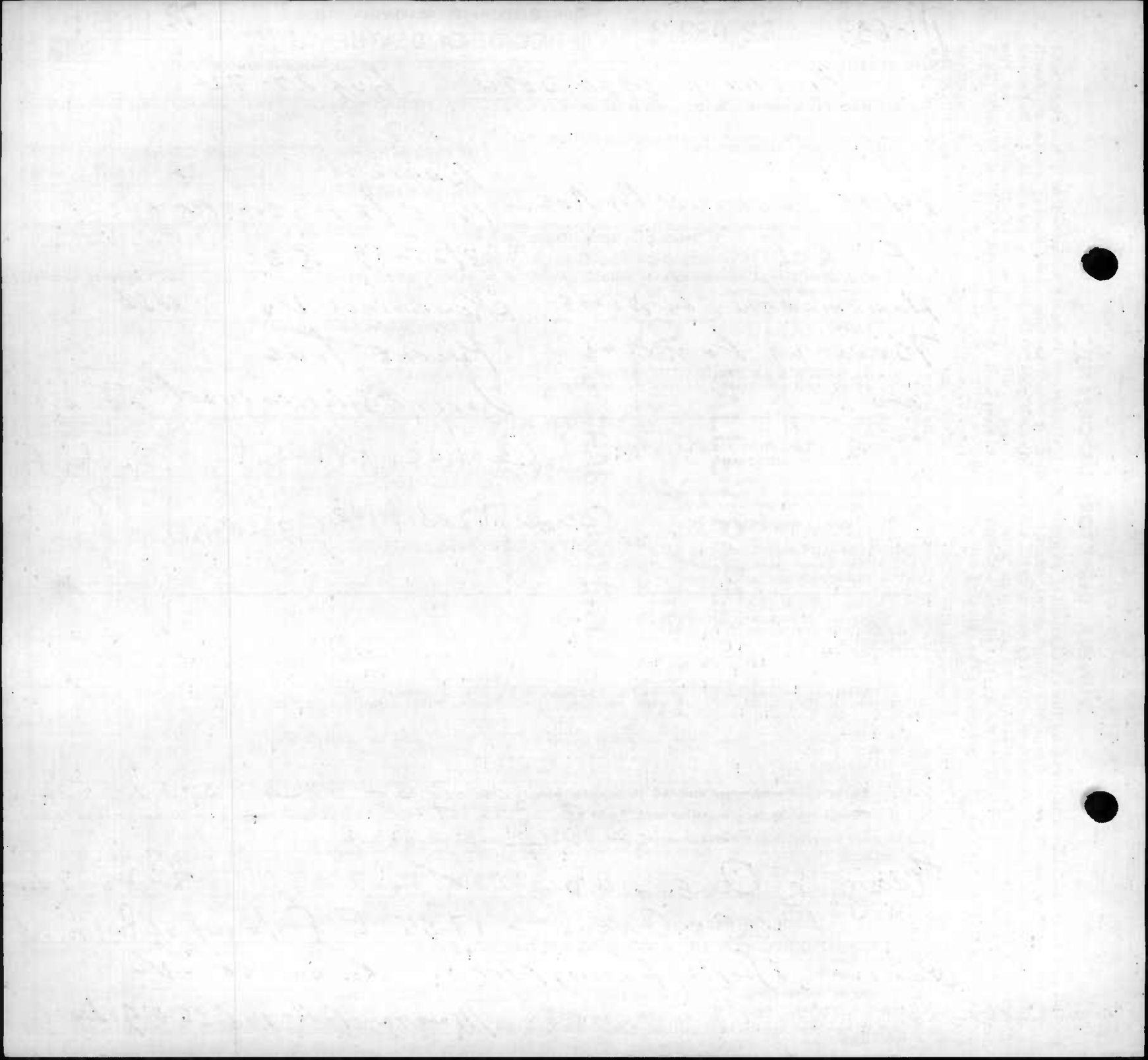
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>533,08273</u>	
G-620 72 08273		STATE OF MARYLAND-DEMH	
BIRTH NO. <u>10663</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>George, Eric</u>		2. DATE AND HOUR OF DEATH <u>8-26-72 1:17 am</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hospital of Baltimore</u> <u>Belvoir Ave at open Spring 21215</u>		A. STATE <u>MD</u> B. COUNTY <u>2798</u>	
		C. CITY OR TOWN <u>City Baltimore</u>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3603 Oakmont Ave</u>	
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-21-72</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years or lost birthday) <u>1</u> <u>5</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore The Hospital America</u>	
13. FATHER'S NAME <u>Frank N. George</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Hazel Hisman</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>From the chart of pt</u>	
18. <u>009.21</u>		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<u>Cardiac arrest secondary to</u>	
ANTECEDENT CAUSES		<u>Severe dehydration</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<u>Electrolyte imbalance</u>	
		<u>metabolic acidosis</u>	
		<u>Severe gastric enteritis, dehydration</u>	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>8-25-72 11 pm</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cut down for IV therapy</u>	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8 PM 8-25-1972</u> to <u>1:17 am 8-26-1972</u> that (I) (we) last saw the deceased alive on <u>11:45 pm 8-25-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>A. Shakhidze</u>		23B. DATE SIGNED <u>8-26-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. SHAHIDEH</u>		23D. ADDRESS <u>Sinai Hospital of Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>8/29/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore (AA Co.) Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 29 1972</u>		25B. NAME OF REGISTRAR <u>Dwight Johnson</u>	
		25C. FUNERAL DIRECTOR ADDRESS <u>LEWIS T GWYNN 4517 PARK HEIGHTS AVE.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

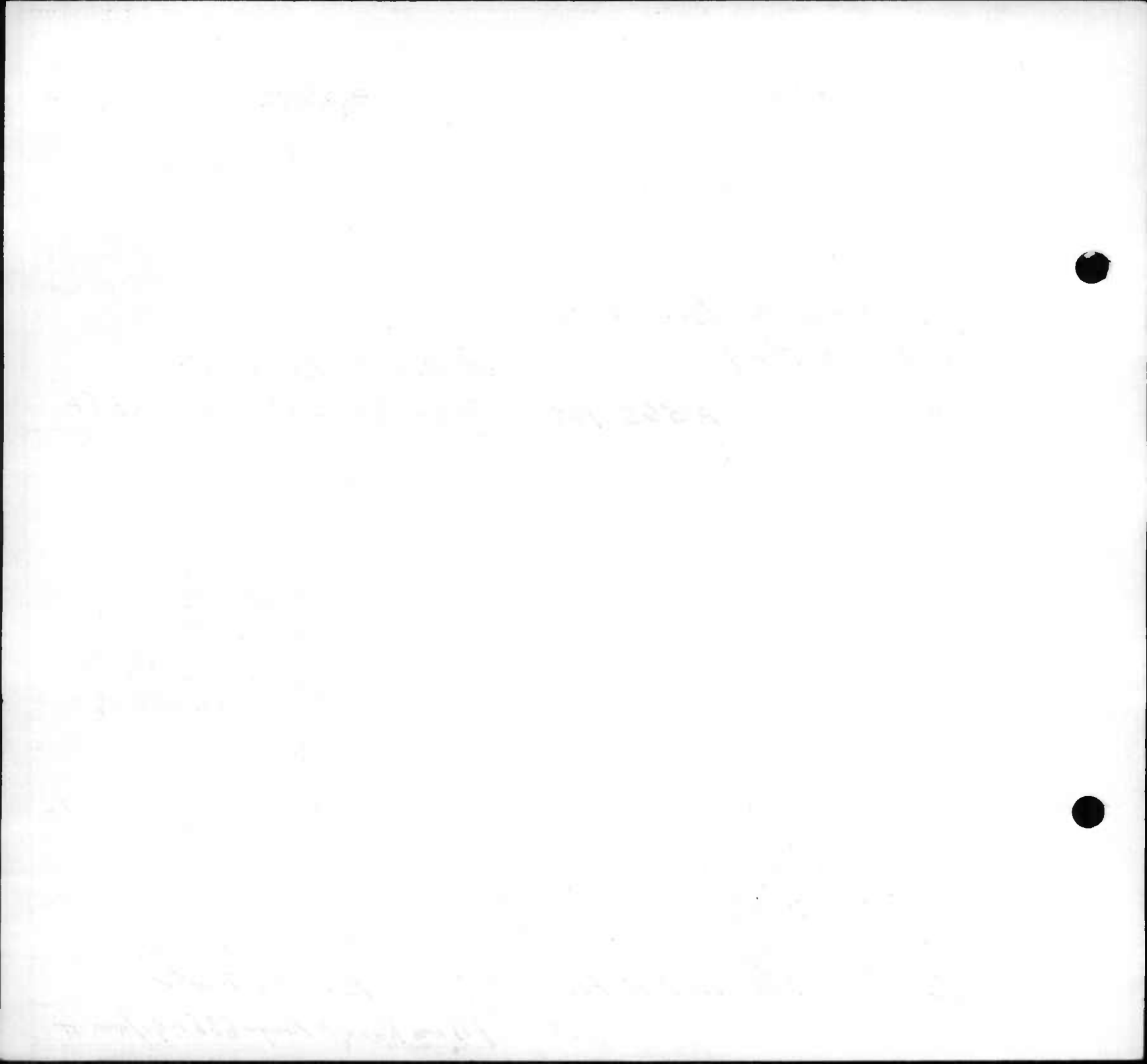
M-633		72 08274		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08274	
BIRTH NO.				STATE OF MARYLAND-DEMD			
1. NAME OF DECEASED (Type or Print) VICTORIA MERIDETH				2. DATE AND HOUR OF DEATH Aug 27-72			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 804			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
1405 PATTERSON PK AVE				E. STREET AND NUMBER 1405 PATTERSON PK AVE			
5. SEX F	6. RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25-89	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Kenaridoo Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Beverly Lowmiller				14. MOTHER'S MAIDEN NAME Florence Todd			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Louis Eggleston 1405 Patterson Ave			
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cardiac Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant ?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-26-1972 to 8-27-1972, that (I) (we) last saw the deceased alive on August 24 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Eugene Owens MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 8-28-72	
23C. PHYSICIAN'S NAME (Type) Eugene Owens MD				23D. ADDRESS 1735 E. Federal St Balto, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/28/72		24C. NAME OF CEMETERY OR CREMATORY Family Plot		24D. LOCATION (City, town, or county) (State) Kenaridoo - Va	
25A. DATE REC'D BY HEALTH DEPT. AUG 29 1972		25B. NAME OF REGISTRAR Bridget H. Heston		25C. FUNERAL DIRECTOR Margaret P. Hays		ADDRESS 638 N. G. 1st St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>R-000</span> <span>72 08275</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 72 08275 STATE OF MARYLAND - DHMH	
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) <b>RAY, SCOTT</b>		2. DATE AND HOUR OF DEATH <b>8/26/72 9 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MD. HOSPITAL 38</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1603</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>536 N. MOUNT ST.</b>	
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/5/92</b>
9. AGE (in years last birthday) <b>80</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Porton</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O. R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES RAY</b>		14. MOTHER'S MAIDEN NAME <b>Emma Leopold</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>A865-165</b>	
17. INFORMANT <b>Corra Ray</b>		ADDRESS <b>536 N. Mount St</b>	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CEREBROVASCULAR ACCIDENT</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>URINARY TRACT INFECTION</b>		(C) _____	
19A. DATE OF OPERATION <b>8/30/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>20 AUGUST 1972</b> to <b>26 AUGUST 1972</b> that (I) (we) last saw the deceased alive on <b>26 AUGUST 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>John Wolfe Blotzer</b>		23B. DATE SIGNED <b>26 AUGUST 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOHN WOLFE BLOTZER</b>		23D. ADDRESS <b>6 RIDGEBURY CT BALTIMORE, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burned</b>		24B. DATE <b>8/30/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>MT AUBURN</b>		24D. LOCATION (City, town or county) (State) <b>BALTIMORE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Frederick H. Hooton</b>	
25C. FUNERAL DIRECTOR <b>Myra Ann H. Hooton</b>		ADDRESS <b>638 N. G. / MOUNT ST</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-252		72 08276		BALTIMORE CITY HEALTH DEPARTMENT		72 08276	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HAWKINS, Clara BELL				8/29/72 3-15 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
Lutheran Hosp.				1538			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN			
				BALTO, MD			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER							
3446 REDMONT AVE							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 Yr. Months	10. UNDER 24 Hrs. Days	10. UNDER 24 Hrs. Hours
F	N	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11-8-88	83			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Homemaker				At Home			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
BALTO MD				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph H. Cooper				Clara E. Key			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no							
17. INFORMANT				ADDRESS			
Sadie Gunnison				3446 Redmont			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Pulmonary Embolism			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cerebrovascular Accident.			
				DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Atherosclerotic Heart Disease.			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/24/72 to 8/29/72 that (I) (we) last saw the deceased alive on 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
E. SANDOZ, M.D.				8/29/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8/31/72		BALTO NATIONAL		BALTO MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 29 1972		Sidney H. Weston		Benjamin R. Brown		638 1/2 Gilmor St	



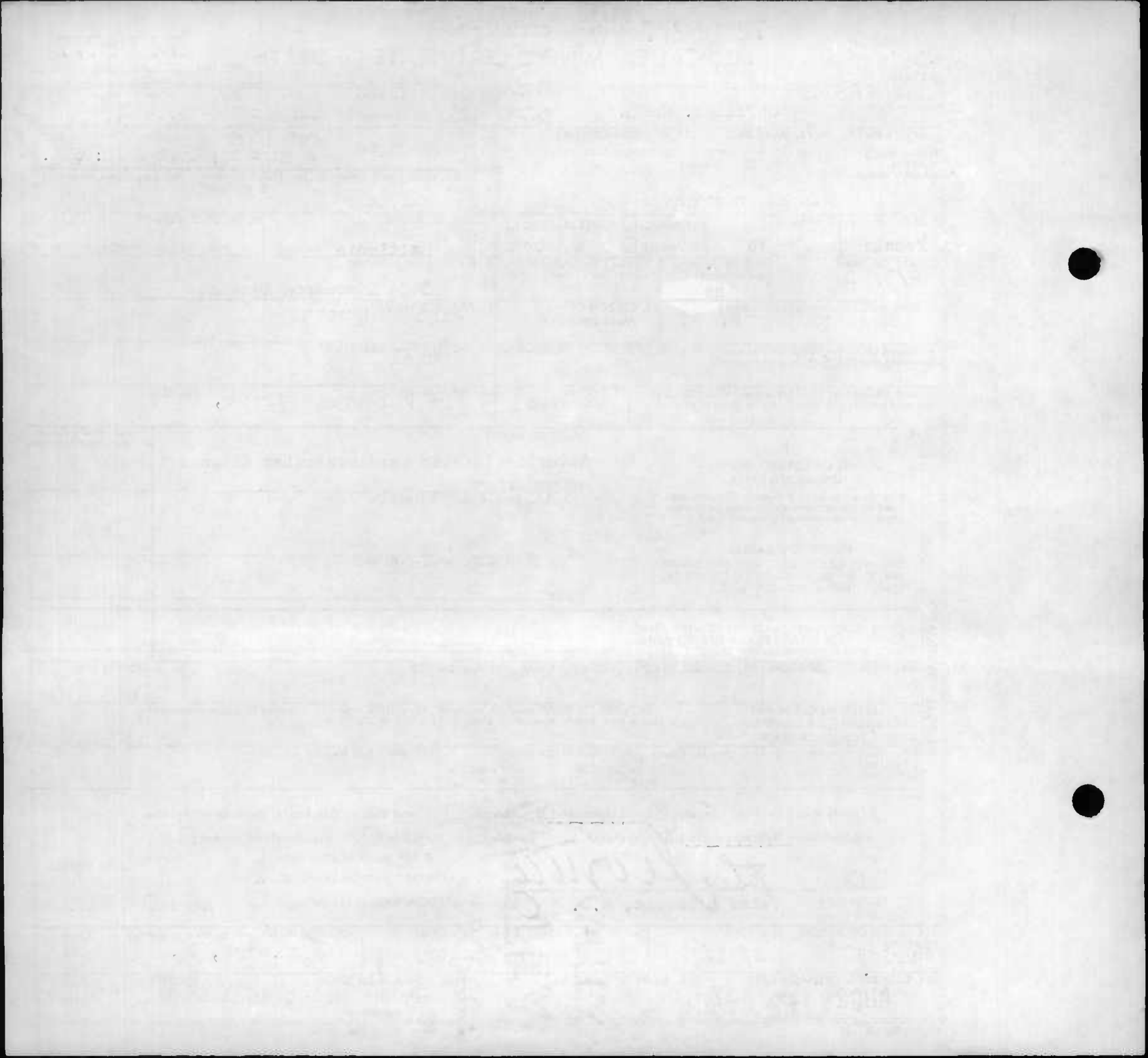
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08277

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SOPHIA V. GREEN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>August 26, 1972</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 3426 Edmondson Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 26, 1972 8:05 A.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9/3/92</b>		10. AGE (In years lost birthday) <b>79</b>	
11. BIRTHPLACE (State or foreign country) <b>Eastern Shore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>A</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		15. MOTHER'S MAIDEN NAME <b>Rachel</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs Margaret Marcus, Same</b>		ADDRESS	
19. <b>4124</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 27, 1972</b> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/31/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 29 1972</b>		25B. NAME OF REGISTRAR <b>Adolphus Halstead</b>	
25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>1206 W North Ave</b>	

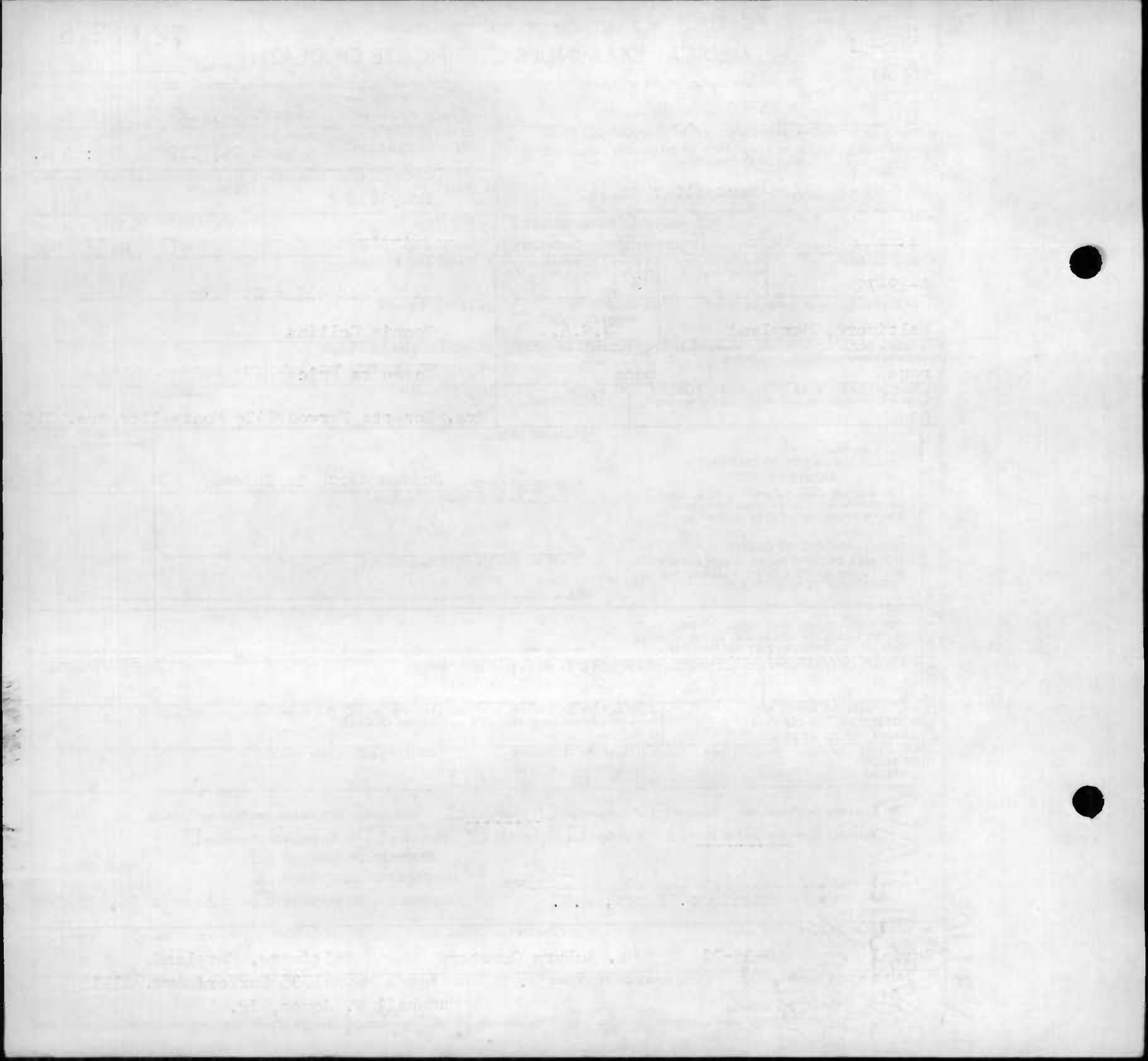


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 72-06573

1. NAME OF DECEASED (Type or Print) <b>LISA VANTORIA COLLINS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 24, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1426 Montpelier Street</b>		3. DATE PRONOUNCED DEAD Month Day Year August 24, 1972		Hour M. 8:15 A.	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 4-29-72		10. AGE (In years last birthday) 3		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Ronnie Collins		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
15. MOTHER'S MAIDEN NAME Casandra Price		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Loretta Zervos		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Sudden death in infancy</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 24, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-28-72		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 29 1972		25B. NAME OF REGISTRAR Marshall W. Jones, Jr.	
25C. FUNERAL DIRECTOR 1735 Harford Ave.		25D. ADDRESS 21213			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08279

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

ROLAND A. JONES

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

## 3. DATE

Month

Day

Year

Hour

M.

## PRONOUNCED DEAD

August 21, 1972

10:50 P.

## 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

D.C.

B. COUNTY

V 48

## 6. SEX

Male

## 7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Washington

## D. INSIDE CITY LIMITS?

YES ☒NO ☐

## 9. DATE OF BIRTH

3/03/1943

10. AGE (In years  
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

## E. STREET AND NUMBER

219 Atlantic Street, S.E.

## 11. BIRTHPLACE (State or foreign country)

Maryland

## 12. CITIZEN OF

WHAT COUNTRY?

U.S.

## 13. FATHER'S NAME

Norman Jones

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor

## 14B. KIND OF BUSINESS OR INDUSTRY

## 15. MOTHER'S MAIDEN NAME

Mary Holland

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

214-42-1188

## 18. INFORMANT

## ADDRESS

Norman Jones Chesapeake Beach, Md.

## 19.

## CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Shotgun wound of leg

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

## 20A. DATE OF OPERATION

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING ☒ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

House

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Dalympla Bridge Rd. Chesapeake

Beach, Calvert County, Md.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

8-21-72

5:18 P.m.

## 22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

## 22F. HOW DID INJURY OCCUR?

Shot during altercation

## 23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/22/72

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

## 24B. DATE

8/25/72

## 24C. NAME of CEMETERY or CREMATORY

St. Edmonds Chr. Cem.

## 24D. LOCATION (City, town, or county)

Calvert Co., Md.

## 25A. DATE REC'D BY HEALTH DEPT.

AUG 29 1972

## 25B. NAME OF REGISTRAR

Sidney Whiston

## 25C. FUNERAL DIRECTOR

Pinkney E. Sewell Pr. Fred., Md.

## ADDRESS

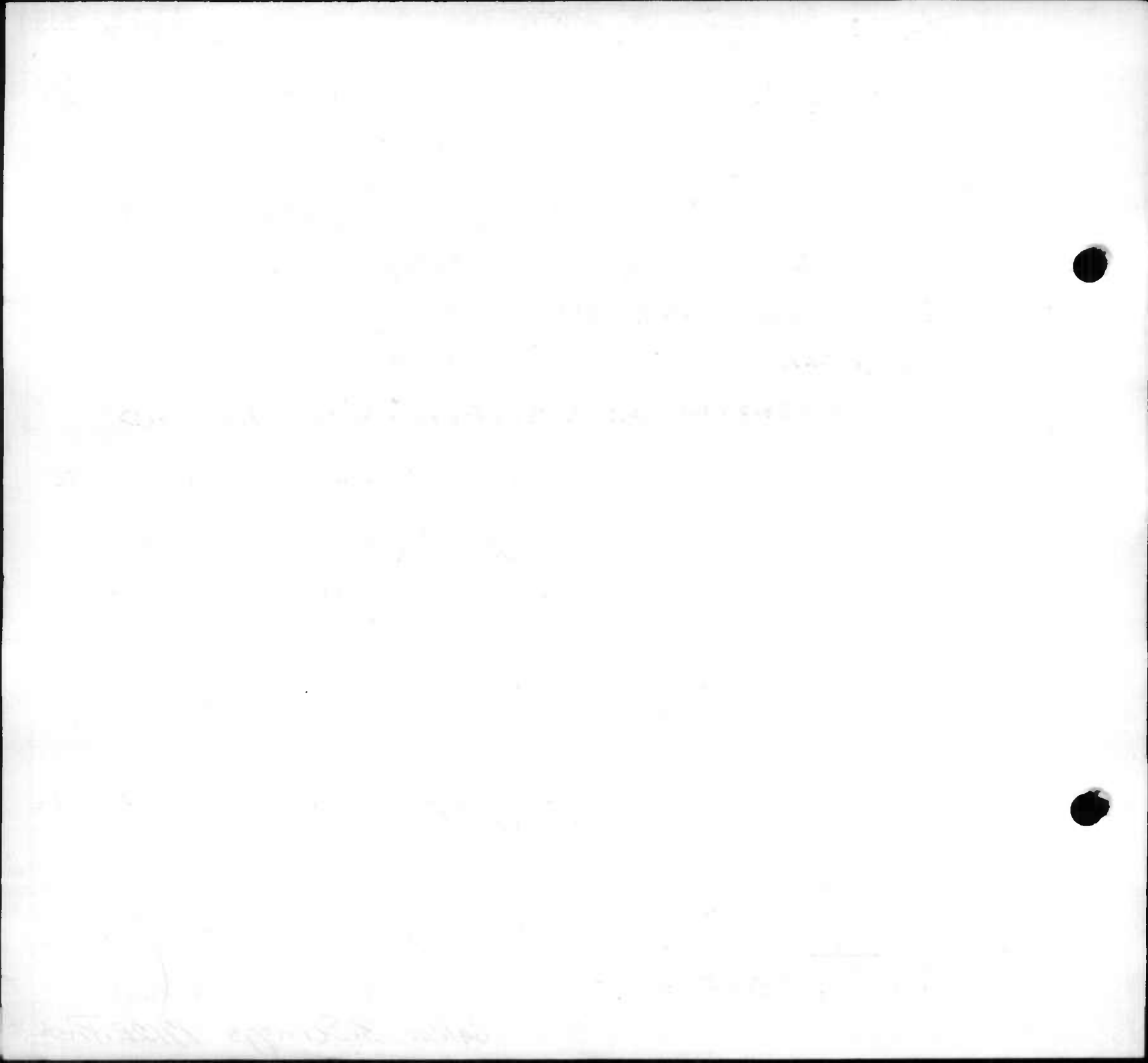


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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

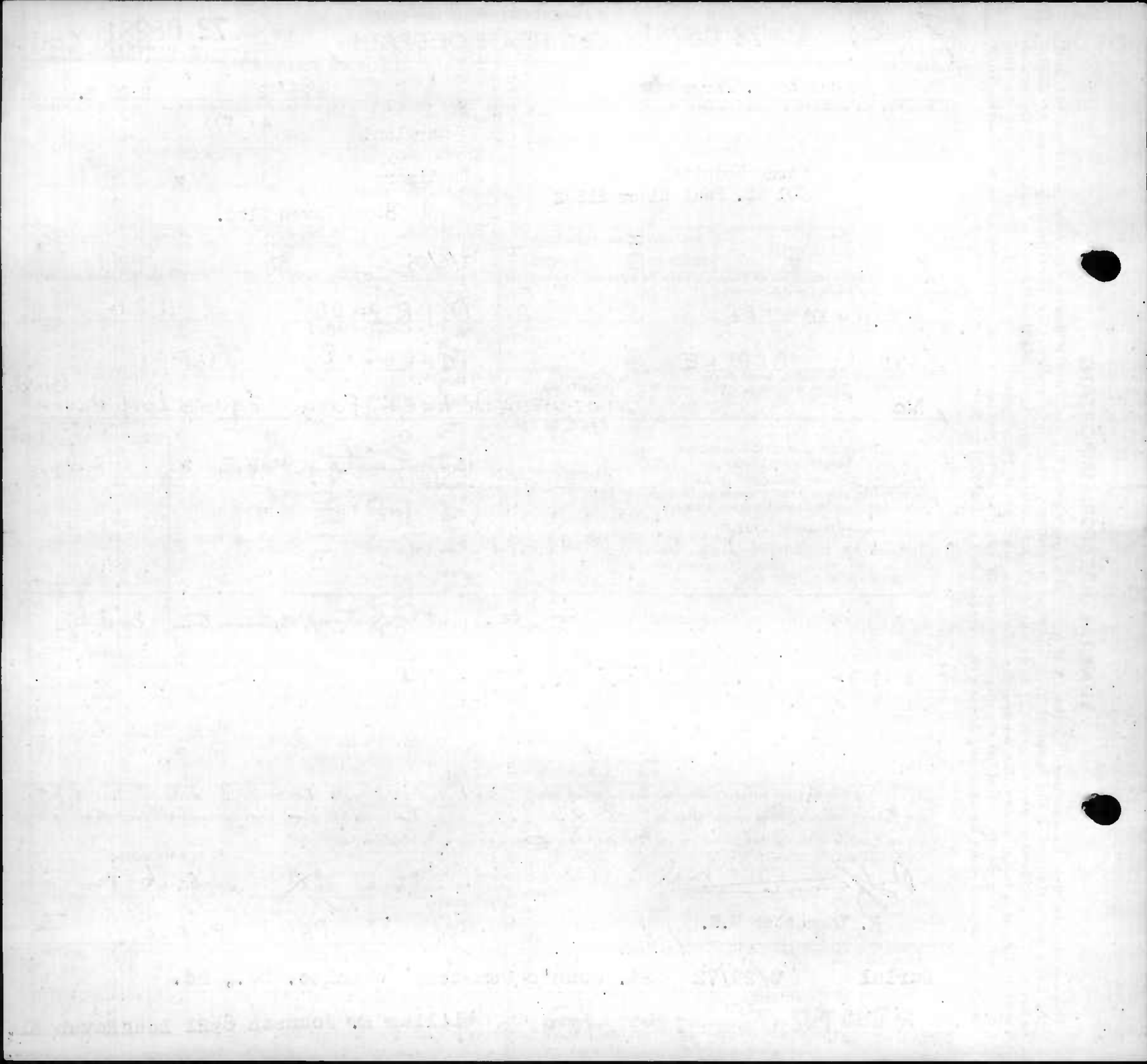
D-620		72 08280		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 2794		72 08280	
BIRTH NO.		CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
DORSEY, LAURD		8/29/72 6:30 PM				BOLTON HILL NURSING HOME 1400 JOHN ST. BALTO. MD.			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		A. STATE		B. COUNTY	
BOLTON HILL NURSING HOME		1400 JOHN ST. BALTO. MD.		MARYLAND		BALTIMORE		833	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		D. INSIDE CITY LIMITS?	
UNKNOWN		UNKNOWN		UNKNOWN		USA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
UNKNOWN		UNKNOWN		UNKNOWN		215-22-0572		ADMISSION RECORD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				acute coronary occlusion			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:				hypertensive C.V. disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:				arteriosclerosis generalized			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				some diabetes			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
8/27		enlargement with hypertrophy		No		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
No		21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
No		21D. TIME OF INJURY (Approx.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		No			
22. I certify that (I) (this hospital) attended the deceased from		8/27		1972 to		8/29		1972	
that (I) (we) last saw the deceased alive on		8/29		1972		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNDAL DIRECTOR	
[Signature]		8/29/72		[Signature]		2 E. Bond St. Baltimore 21201		[Signature]	
24A. SURIAL REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		24E. FUNDAL DIRECTOR	
Removal		8-31-72		Mt. Hope		Hastings on the Hudson		[Signature]	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNDAL DIRECTOR		25D. ADDRESS		25E. FUNDAL DIRECTOR	
AUG 30 1972		[Signature]		[Signature]		1512 E. Federal St.		[Signature]	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08281		72 08281	
7-620				72 08281		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>Jeannette C. Fargo</b>				2. DATE AND HOUR OF DEATH <b>8/26/72</b> <b>2:00 P.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b> <b>301 St. Paul Place 21202</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>8405B Loch Raven Blvd.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/6/05</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home-maker</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>WM J. CLARKE</b>			
14. MOTHER'S MAIDEN NAME <b>MARGARET DUFFY</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>			
16. SOCIAL SECURITY NO. <b>219-07-2185A</b>				17. INFORMANT <b>Dr. Lee K. Fargo</b> ADDRESS <b>8405B Loch Raven Blvd.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>7-58-71</b> <b>CAUSE OF DEATH</b> <b>Retropneumothorax</b> <b>1-2 days</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>Status post colectomy, splenectomy</b> <b>2 days</b>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>8-23-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Common duct stones</b> <b>distended same</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (A) (this hospital) attended the deceased from <b>8-1-72</b> to <b>8-26-72</b> and that (B) (we) lost saw the deceased alive on <b>8-26-72</b> and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>R. Lancaster M.D.</b>				23B. DATE SIGNED <b>8-26-72</b>		23C. PHYSICIAN'S NAME (Type) <b>R. Lancaster M.D.</b>	
23D. ADDRESS <b>301 ST. PAUL PLACE</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>8/29/72</b>				24C. NAME of CEMETERY or CREMATORY <b>St. John's Cemetery</b>			
24D. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>			
25B. NAME OF REGISTRAR <b>Audrey [Signature]</b>				25C. FUNERAL DIRECTOR <b>William E. Johnson</b> ADDRESS <b>8521 Loch Raven Bl.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-623		72 08282		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08282	
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) <b>JAMES W. BRITTON</b>				2. DATE AND HOUR OF DEATH <b>8/26/72 1523 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b> 6. RACE <b>Cauc.</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>9/27/99</b>		9. AGE (In years last birthday) <b>72</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insattment Seller</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>James Britton</b>			
14. MOTHER'S MAIDEN NAME <b>Sara Hoffman</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>217-54-8803</b>				17. INFORMANT <b>Family records</b>			
18. CAUSE OF DEATH <b>412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>ATRIAL FIB 2:1, 3:1 Block</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b> <b>8 yrs</b> <b>&gt; 8 yrs</b> <b>1 wk</b>			
19A. DATE OF OPERATION <b>2/1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/21</b> 19 <b>72</b> to <b>8/26</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/26</b> 19 <b>72</b> and that (in my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John B. Welch M.D. Ph.D.</b>				23B. DATE SIGNED <b>8/26/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOHN B. WELCH M.D. Ph.D.</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSP. BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 29, 1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Prospect Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Towson, Maryland MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Sidney B. ...</b>		25C. FUNERAL DIRECTOR <b>John Boring Sons, Towson, Maryland</b>		ADDRESS	

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72 08283

STATE OF MARYLAND-DEATH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08283

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES ENGE, Sr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 26, 1972	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour August 26, 1972 6:55 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov. 30, 1906		10. AGE (In years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silver Smith		14B. KIND OF BUSINESS OR INDUSTRY Stieff's	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-05-9140	
18. INFORMANT (Wife) 603 South Oldham St. Mrs. Catherine L. Enge, Balto. Md.		15. MOTHER'S MAIDEN NAME	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: August 27, 1972 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/29/72	
24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 30 1972		25B. NAME OF REGISTRAR Andrew Thornton	
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		ADDRESS	

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		72 08284		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08284	
BIRTH NO.		GERTRUDE JONES		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) Gertrude Jones		2. DATE AND HOUR OF DEATH 8/22/72 1 30 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-02	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BCH: RECORDS 4940 Eastern Ave. Balto. Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: electrical mechanical dissection 6-7 days (B) DUE TO, OR AS A CONSEQUENCE OF: congestive heart failure (C) DUE TO, OR AS A CONSEQUENCE OF: Rheumatic heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from Aug. 18 19 72 to Aug. 22 19 72, that (I) (we) last saw the deceased alive on Aug. 22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Philip L. Smith MD				23B. DATE SIGNED 8/22/72		23C. PHYSICIAN'S NAME (Type) PHILIP L. SMITH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-28-72		24C. NAME of CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 30 1972		25B. NAME OF REGISTRAR Anthony J. Jones		25C. FUNERAL DIRECTOR Walter Gabanick		25D. ADDRESS 1005 Dundalk Ave	

250 S. East Ave 21224

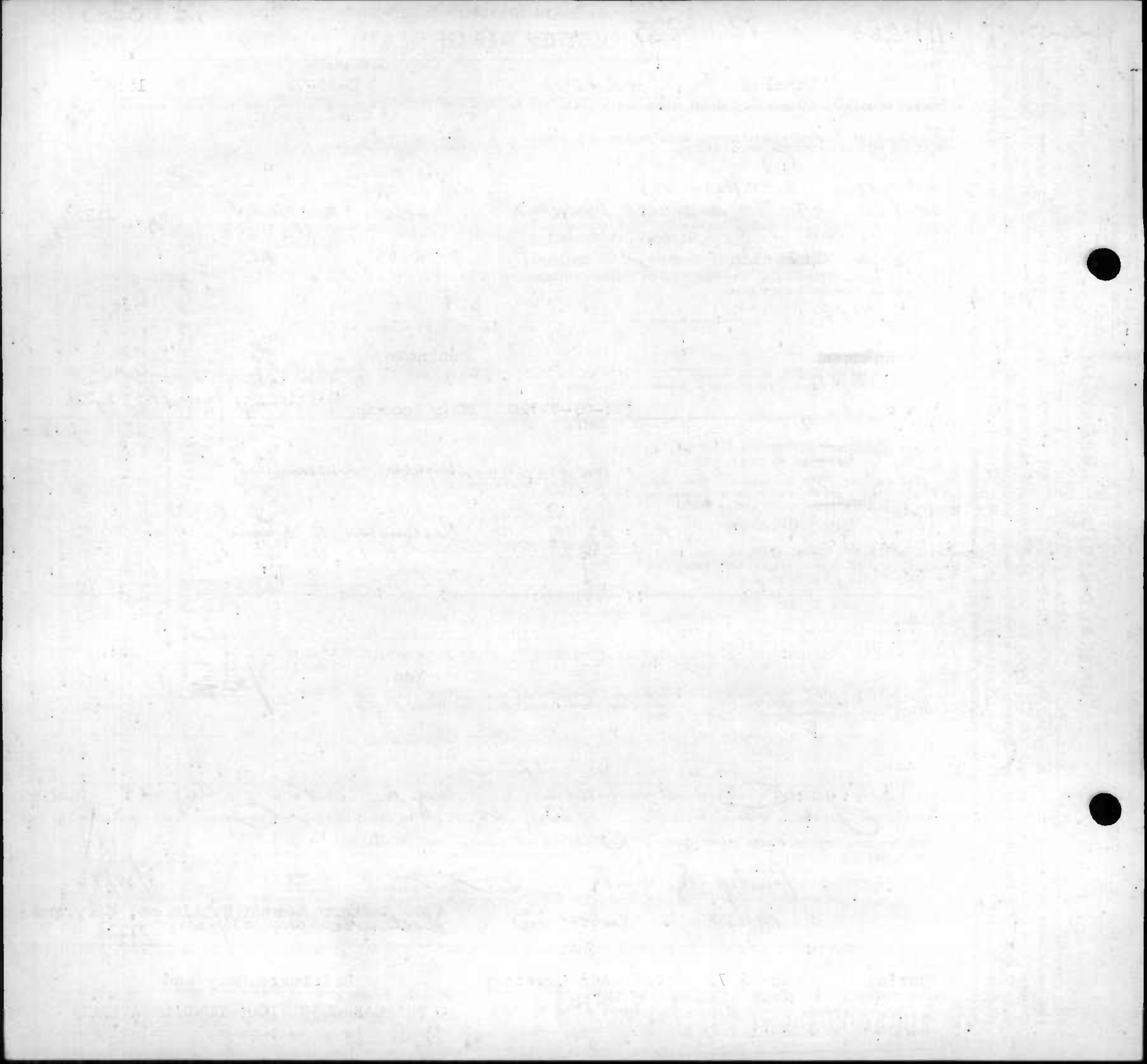
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61-03-57  
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08285		72 08285	
M-263				CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>Ethel M. Grader</b>				2. DATE AND HOUR OF DEATH <b>8-25-72 12:45 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS EASTERN AVE BALTIMORE, MARYLAND.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2646</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6305 FORTICW Way 21224</b>			
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-5-99</b>		9. AGE (In years last birthday) <b>72</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>274-03-7772D</b>		17. INFORMANT <b>4940 Eastern Avenue Baltimore, Maryland 21224</b> BCH: Records			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>1802.9 I</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>thromia - uncontrolled</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Carcinoma of uterus</b> DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <b>Aug 18 19 72</b> to <b>Aug 25 19 72</b> , that (I) (we) last saw the deceased alive on <b>Aug 25 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Philip L. Smith</b> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/25/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>PHILIP L. SMITH MD</b> DEGREE				23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland Baltimore City Hospitals. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-28-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Lidney</b>		25C. FUNERAL DIRECTOR <b>WALTER DABROWSKI 1005 DUNDALK AVENUE</b> ADDRESS			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08286		72 08286	
BIRTH NO. P-456		72 08286		STATE OF MARYLAND - DHME	
1. NAME OF DECEASED (Type or Print) <b>PLUMMER, FLORENCE M.</b>		2. DATE AND HOUR OF DEATH <b>8-27-72 10-23 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>NORTH CHARLES HOSPITAL BALTIMORE MD</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3506 JEAN DRIVE 21207</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-90</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>VA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>BURTON B. HALL</b>			
14. MOTHER'S MAIDEN NAME <b>MERTIE D. JONES</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>			
16. SOCIAL SECURITY NO. <b>577-40-3653</b>		17. INFORMANT <b>MRS ADELE MILLS, 3506 JEAN DRIVE BALTIMORE MD 21207</b>			
18. CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>VIRAL MENINGITIS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>VIRAL MENINGITIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>E.A.S.H.D.</b> (C) _____ <b>A.S.H.D AND DUODENAL ULCER</b>			
19A. DATE OF OPERATION <b>8-24-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>-</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (Approx.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (A) (this hospital) attended the deceased from <b>8-24-72</b> 19 <b>72</b> to <b>8-27-72</b> 19 <b>72</b> that (B) (we) last saw the deceased alive on <b>8-27-72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>SK MILAK M.D.</b>		23B. DATE SIGNED <b>8-27-72</b>		23C. PHYSICIAN'S NAME (Type) <b>DR SK MILAK</b>	
23D. ADDRESS <b>N. CHARLES HOSPITAL BALTO</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>8/31/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mine Road Baptist Church Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Spotsylvania, Spotsylvania, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Gordon</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>	
25D. ADDRESS <b>8728 Liberty Road, Randallstown, Md. 21133</b>		25E. ADDRESS <b>P.A.</b>			



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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08287	
L-230 72 08287				STATE OF MARYLAND-PHME	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Leggett, Earl B.</b>			2. DATE AND HOUR OF DEATH <b>8/28/72 10:38 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Agnes Hospital Emergency Room 900 Caton Ave. 21229</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>7123 Kitkat Road 21227</b>		
5. SEX <b>M</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/35</b>	9. AGE (In years last birthday) <b>37</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welding Service</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>A.E. Leggett</b>		
14. MOTHER'S MAIDEN NAME <b>Myrtle Deaton</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Hogg Funeral Home, Wicomico, Virginia 23184</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <i>Ventricular fibrillation</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ventricular aneurysm</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Extensive anterior MI</i> (C) <i>Severe coronary arteriosclerosis</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>451</b> <b>1 yr</b> <b>1 yr.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-31-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gloucester Pt. Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Gloucester County, Virginia</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	

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BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)LEO  
ERNEST/BOONE2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

BALTIMORE 2831

6. SEX

male

7. RACE

white

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

APRIL 22 - 1916

10. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

5415 CRISMER  
Ave.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

FREDERICK BOONE

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CARPENTER

14B. KIND OF BUSINESS OR INDUSTRY

BUILDING

15. MOTHER'S MAIDEN NAME

CHRISTINA MURK

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

WWII

WWII

17. SOCIAL  
SECURITY NO.

216-03-9104

18. INFORMANT

ADDRESS

SHARON RETALLACK EDGEWATER MD

19.

CAUSE OF DEATH

Multiple blunt force injuries

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Fatty metamorphosis of liver

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

parking lot

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCURRED  
rear 5207 Reisterstown Rd.22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

8-27-72

10:30 a

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Beaten during argument.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8-28-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

AUG 30 - 1972

24C. NAME of CEMETERY or CREMATORY

PIPE CREEK

24D. LOCATION (City, town, or county)

NEW WINDSOR

(State)

MD

25A. DATE REC'D BY HEALTH DEPT

AUG 30 1972

25B. NAME OF REGISTRAR

Ardrey Wharton

25C. FUNERAL DIRECTOR

D. Hartley &amp; Sons

ADDRESS

New Windsor

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1-500 71-18908 72 08289		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 08289 STATE OF MARYLAND-DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <b>DAWN LANE</b>		2. DATE AND HOUR OF DEATH <b>8/27/72 6:40 pm</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>GLEN BURNIE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>309 COLBY CIRCLE</b> 21061			
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-8-71</b>	9. AGE (In years last birthday) <b>9</b>	If Under 1 Yr. Months: <b>20</b> Days: <b>20</b> Hours: <b>20</b> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>THOMAS LANE</b>		14. MOTHER'S MAIDEN NAME <b>SANDRA L. St. John</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>BCH: RECORDS 4940 Eastern Avenue</b> <b>FATHER</b> Baltimore, Maryland 21224	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRAIN / INTERNAL HEMORRHAGE?</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIO-RESPIRATORY ARREST - ON RESPIRATOR</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>SEPSIS</b> (C) <b>DIFFUSE BRAIN DAMAGE</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>8/27/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9 am 8/27/72</b> to <b>6:40 pm 8/27/72</b> that (I) (we) last saw the deceased alive on <b>6:40 pm 8/27/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>E. Contreras MD.</b>		23B. DATE SIGNED <b>8/27/72</b>		23C. PHYSICIAN'S NAME (Type) <b>E. CONTRERAS M.D.</b>	
23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>		24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>8/30/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Andrew J. Porten</b>		25C. FUNERAL DIRECTOR <b>Amrose J. 1328 Solphur Sq. Rd</b>	

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08290

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Gilman H. Hood</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>8</b> Day <b>28</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Balto. Gen. Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>28</b> Year <b>72</b> Hour <b>2:15 p.</b> M.	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>3/23/1957</b>		10. AGE (In years last birthday) <b>15</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jefferson Hood</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Isaac</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		16. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO. <b>21230</b>	
19. CAUSE OF DEATH <b>E910.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Drowning</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>8/31/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Water</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2400 block S. Charles St. rear of Norris Boat Yard</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>8 28 72 1:45 p.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject drowned while swimming.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Marvin S. Platt</b> M.D. EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b> DATE SIGNED <b>8/29/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>8/31/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Green Hill Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Bolton Ph. G. G. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Henry Conway, Jr.</b>		25D. ADDRESS <b>901 Jackson St</b>	



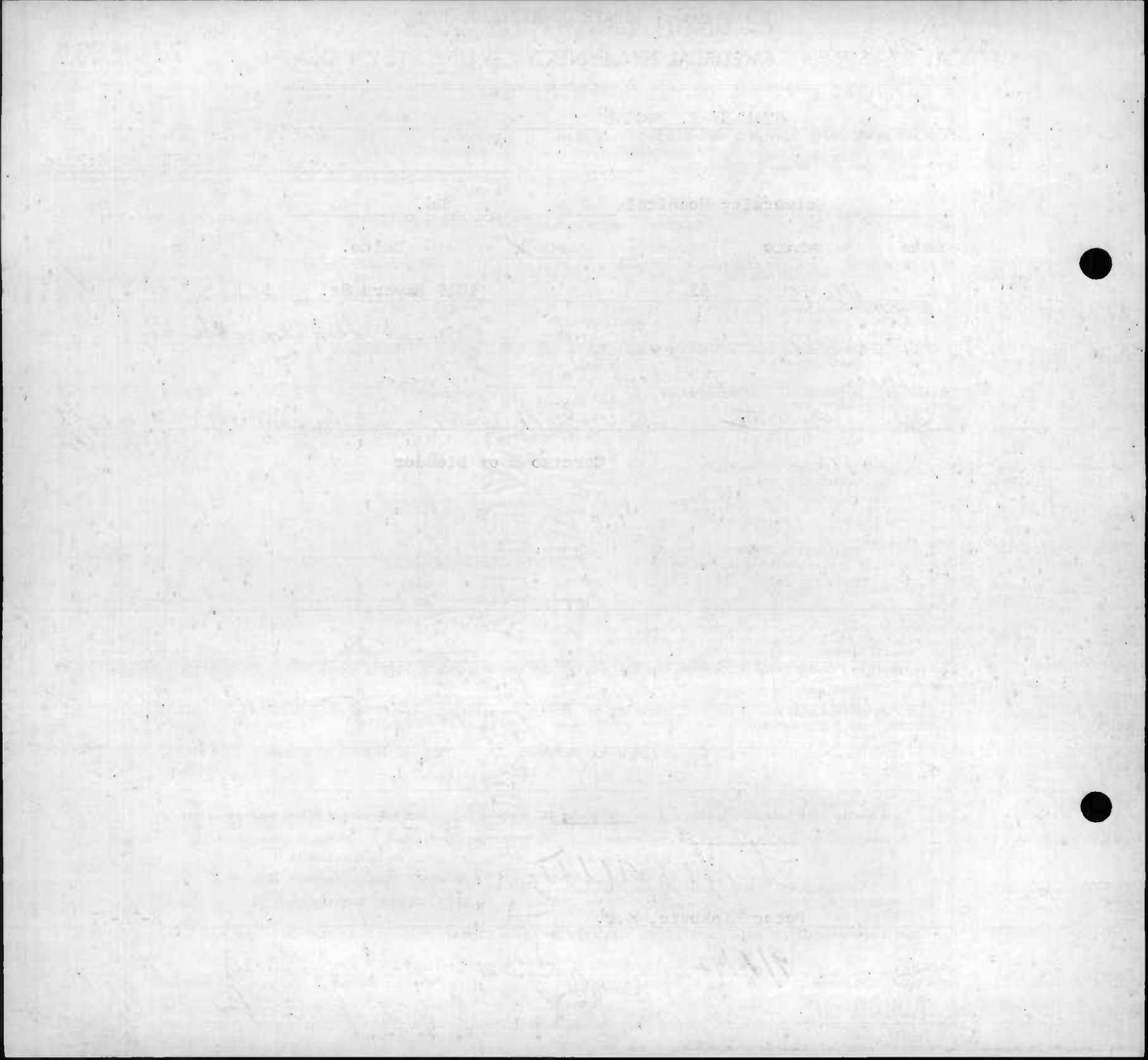
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08291

## BIRTH NO.

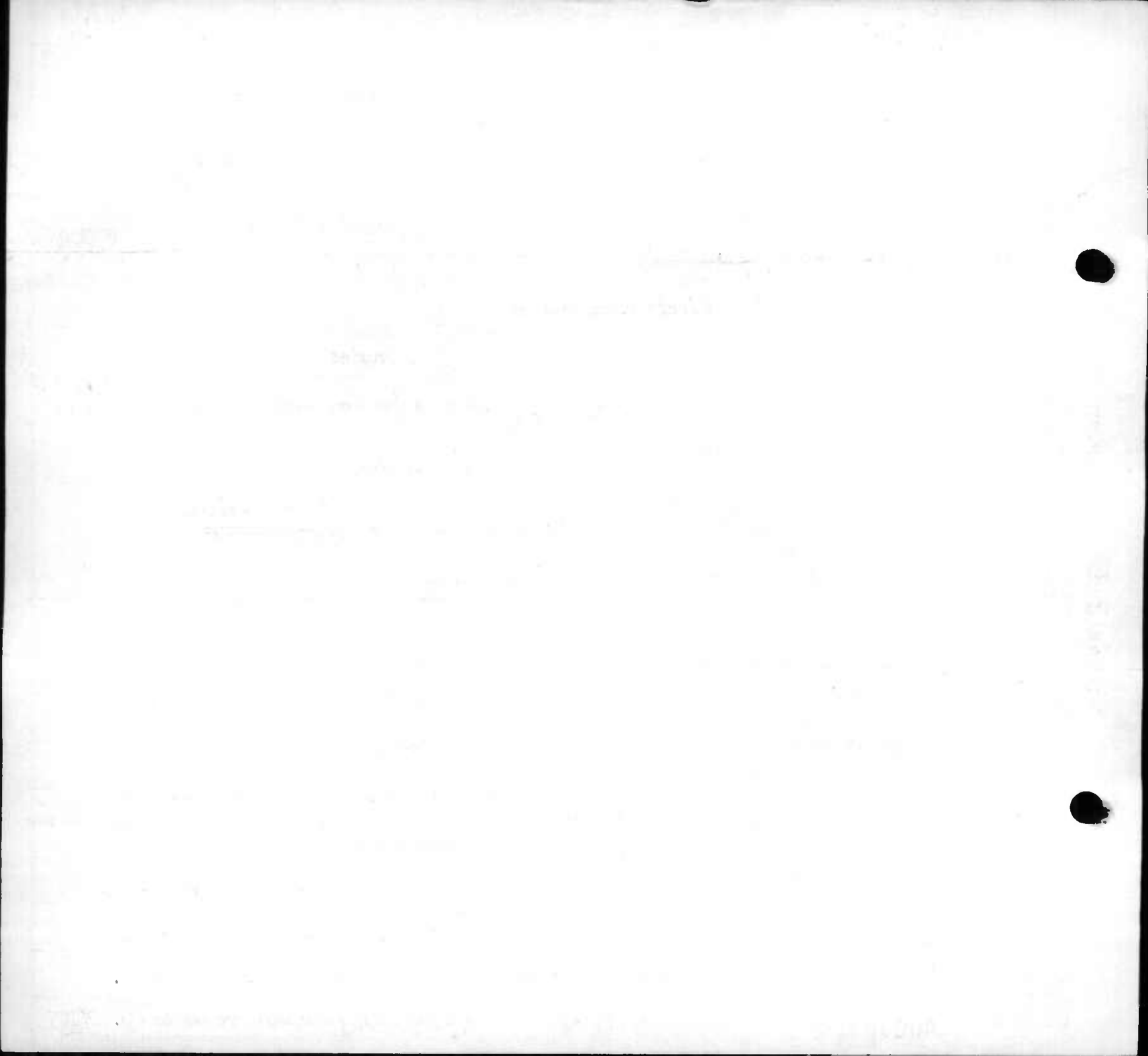
1. NAME OF DECEASED (Type or Print) <b>STANLEY F. PACKAL</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 27 1972 8:25 PM</b>			
6. SEX <b>male</b>				7. RACE <b>white</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2102</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH <b>Jan 4 1909</b>		10. AGE (In years last birthday) <b>63</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Kasimir Pakalnis Chasky</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		15. MOTHER'S MAIDEN NAME <b>Ludwiga ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes. Gr. M. II</b>	
17. SOCIAL SECURITY NO. <b>212-09-8674</b>		18. INFORMANT <b>Anton J. Pakalnis</b>		19. ADDRESS <b>1019 Bayard St.</b>			
CAUSE OF DEATH <b>Carcinoma of bladder</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION <b>9/1/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> DATE SIGNED <b>8-28-72</b> EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>buried</b>		24B. DATE <b>9/1/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnson</b>		25C. FUNERAL DIRECTOR <b>John J. Chovanston Inc.</b>		ADDRESS <b>901 Hollins St.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-535		72 08292		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08292	
<b>CERTIFICATE OF DEATH</b>				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) <u>VON DEN BOSCH</u> <u>CHARLES</u>				2. DATE AND HOUR OF DEATH <u>8/26/72</u> <u>9:45 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 SOUTH BALT. GEN. HOSP</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2505</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1010 BRISTOL PLACE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-4-06</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Electrician Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMIL</u>				14. MOTHER'S MAIDEN NAME <u>Louise Snyder</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-0297</u>		17. INFORMANT <u>Charles Van Den Bosch 200 Highmeadow Road</u>			
18. <u>163.1</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Mitral Valve Prolapse</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) <u>Removal 2° to Mitral Prolapse</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>Causes</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>8-26-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-22-72</u> 19 to <u>8-26-72</u> 19 that (I) (we) last saw the deceased alive on <u>8-26-72</u> 19 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. Carlos Patalinghug</u>				23B. DATE SIGNED <u>8-26-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Carlos Patalinghug</u>	
23D. ADDRESS <u>SOUTH BALT GEN. HOSP.</u>				23E. NAME OF CEMETERY OR CREMATORY <u>Swartz Cemetery</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>8/31/72</u>		24C. LOCATION (City, town, or county) (State) <u>Donnell Street Balto Md.</u>		24D. DATE REC'D BY HEALTH DEPT. <u>AUG 30 1972</u>	
25A. NAME OF REGISTRAR <u>Sidney H. Norton</u>		25B. NAME OF REGISTRAR <u>Sidney H. Norton</u>		25C. FUNERAL DIRECTOR <u>McNulty 2370 Patapsco Ave Balto Md. 21225</u>		25D. ADDRESS <u>2370 Patapsco Ave Balto Md. 21225</u>	



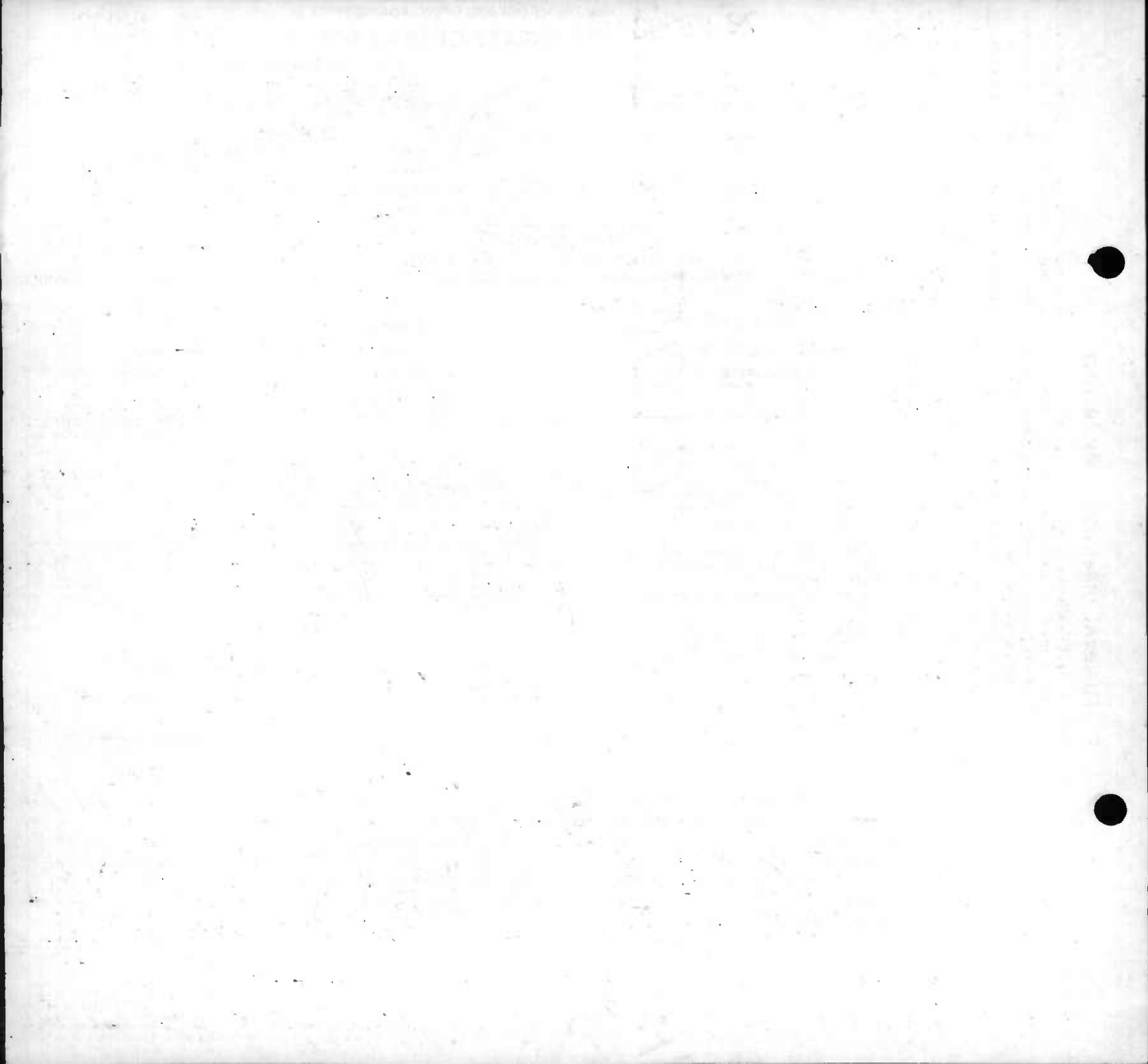


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 08293</u>	
BIRTH NO. <u>V-240</u>		72 08293	
1. NAME OF DECEASED (Type or Print) <u>Vogel George P.</u>		2. DATE AND HOUR OF DEATH <u>8-27-72</u> <u>3 Am</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 CATON MANOR NURSING CENTER</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>TOWSON</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>6 WINTHROP COURT</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 28, 1906</u> 9. AGE (In years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES- RET.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE VOGEL</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Mrs. Ruth H. Jones - 6 Wintthrop Court</u>		ADDRESS <u>                    </u>	
18. <u>185X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of the prostate with metastasis to bone</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>&amp; contiguous spread to</u> (C) <u>palivis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>                    </u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>                    </u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>                    </u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>                    </u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>                    </u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>                    </u>	
22. I certify that (I) (this hospital) attended the deceased from <u>7/17/72</u> to <u>8/27/72</u> that (I) <del>last</del> saw the deceased alive on <u>8/24/72</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>do</del> <u>did</u> (did not) view the body after death.			
23A. SIGNATURE <u>W E McGrath M.D.</u>		23B. DATE SIGNED <u>8/29/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>W E McGrath M.D.</u>		23D. ADDRESS <u>1303 Frederick Rd Catonville 21228 Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>8-30-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 30 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Horton</u>	
25C. FUNERAL DIRECTOR <u>Farley G. Gough</u>		ADDRESS <u>Catonville Md.</u>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

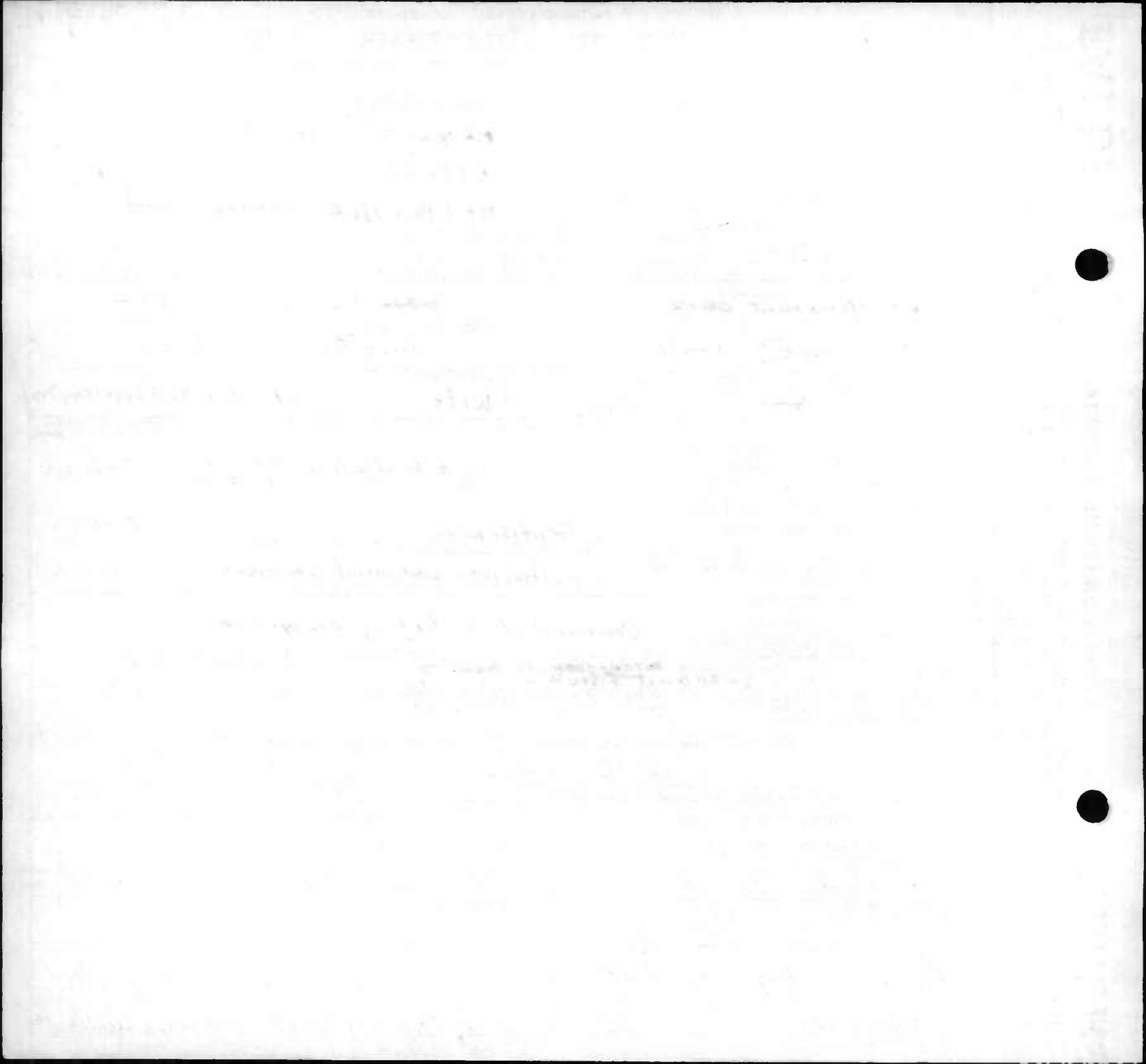
V-562		72 08294		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08294	
BIRTH NO.				STATE OF MARYLAND-DEMH			
1. NAME OF DECEASED (Type or Print) <b>NELLIE VAN ROSSUM</b>				2. DATE AND HOUR OF DEATH <b>0:30 HS AUGUST, 29, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b> <b>44</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALTO, MD</b> B. COUNTY <b>21214</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3106, WEAVER AVENUE -</b> <b>2731</b>			
5. SEX <b>F.</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-1883</b>	9. AGE (In years last birthday) <b>88</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN U.S.A.</b>
13. FATHER'S NAME <b>ROBERT LAFFERTY</b>			14. MOTHER'S MAIDEN NAME <b>MARY SEIDENSTRICKER</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216-03-6641D</b>		17. INFORMANT <b>Miss Nellie Van Rossum,</b>		ADDRESS <b>Same</b>
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCL. CARDIOV. DISEASE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>AGE</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCL. CARDIOV. DISEASE</b> (B) <b>GANGRENE LEFT FOOT DUE TO ART. OBLITERANS</b> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>AGE</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5:30 P.M. 8/28 1972</b> to <b>8:15 A.M. 8/29 1972</b> that (I) (we) last saw the deceased alive on <b>10 P.M. 8/28 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Antonio J. Martins, M.D.</b>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>ANTONIO SANTOS MARTINS, M.D.</b>				23D. ADDRESS <b>"THE UNION MEMORIAL HOSPITAL"</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-1-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck, Inc.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>		ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08295	
G-400		72 08295		STATE OF MARYLAND-DEHE	
1. NAME OF DECEASED (Type or Print) <b>GILL, FOSTER Joseph</b>			2. DATE AND HOUR OF DEATH <b>8-26-72 2:20 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CARROLL</b> C. CITY OR TOWN <b>UPPERCO</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Rt 1 Box 186A Upperco, Md.</b>		
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-27-18</b>	9. AGE (In years last birthday) <b>58</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Government clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Edward J. Gill</b>		
14. MOTHER'S MAIDEN NAME <b>Angela Craver</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>194-09-1202</b>			17. INFORMANT <b>Wife</b> ADDRESS <b>Rt 1 Box 186A Upperco, Md.</b>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>acute renal failure; Bleeding ulcers</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>34 hrs</b>
			(B) <b>Septisemia</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>10 days</b>
			(C) <b>multiple intra abdominal abscesses</b>		<b>3 months</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Common duct obstruction; emphysema</b>					
19A. DATE OF OPERATION <b>8-24-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTERABDOMINAL Abscesses</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-9-72</b> to <b>8-26-72</b> and that (I) (we) last saw the deceased alive on <b>8-26-72</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert M. Smith</b>				23B. DATE SIGNED <b>8-26-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAHASCHAI MUSIKABHONNA</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug. 29, 1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LAKE VIEW MEM. PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>Sykesville, Carroll, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney Johnson</b>		25C. FUNERAL DIRECTOR <b>H. J. Schacht</b> ADDRESS <b>Owings Mills, Md.</b>			



665-20601  
CALL family

STATE OF MARYLAND-DEME  
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08296

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES WESLEY WILLARD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 8-25 or 8-26 1972		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 613 E. Baltimore Street		3. DATE PRONOUNCED DEAD Month Day Year Hour August 26, 1972 8:10 A.M.		
6. SEX Male		7. RACE White		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 11-14-1916		10. AGE (in years lost birthday) 55		
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Bertie Peake
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS 24605 Graham Funeral Home, Bluefield, Virginia

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 27, 1972

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 8-30-1972	24C. NAME OF CEMETERY or CREMATORY Maple Hill Cemetery	24D. LOCATION (City, town, or county) (State) Bluefield, Virginia
25A. DATE REC'D BY HEALTH DEPT. AUG 30 1972		25B. NAME OF REGISTRAR Andrew Houston	25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229

UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]  
DATE: [Illegible]

TO: [Illegible]  
FROM: [Illegible]  
RE: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]

4. [Illegible]  
5. [Illegible]  
6. [Illegible]

7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08297	
M-460				STATE OF MARYLAND-DEM	
BIRTH NO. 72-1301072 08297				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MEILLER, BABY BOY			AUGUST 27, 1972 11:20AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
40 ST. AGNES HOSPITAL			MARYLAND BALTIMORE 21228		
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH			9. AGE (In years last birthday)		
MALE CAUCASIAN WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			07 16 72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
---			MARYLAND - Baltimore		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
JOSEPH J. MEILLER			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No --			None		
17. INFORMANT			ADDRESS		
RECORDS OF ST. AGNES HOSP			CATON & WILKENS AVES. BALTO., MD. 21229		
18. 759.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Respiratory failure		
II			(B) Multiple congenital anomalies since birth		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C) -		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
2			-		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
YES			Lungs.		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		
(Month) (Day) (Year) (Hour)			While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work		
22. I certify that (X) (this hospital) attended the deceased from JULY 16 19 72 to AUGUST 27 19 72, that (X) (we) last saw the deceased alive on AUGUST 27 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			21F. HOW DID INJURY OCCUR?		
23A. SIGNATURE			23B. DATE SIGNED		
Kusuma Pruksapong M.D.			8/27/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
KUSUMA PRUKSAPONG M.D.			BALTO., MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			8/29/72		
24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
New Cathedral Cemetery			Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
AUG 30 1972			Sidney J. Porton		
25C. FUNERAL DIRECTOR			ADDRESS		
Sterling Funeral Estate			736 Edmondson Ave.		
Catonsville, Md. 21228					

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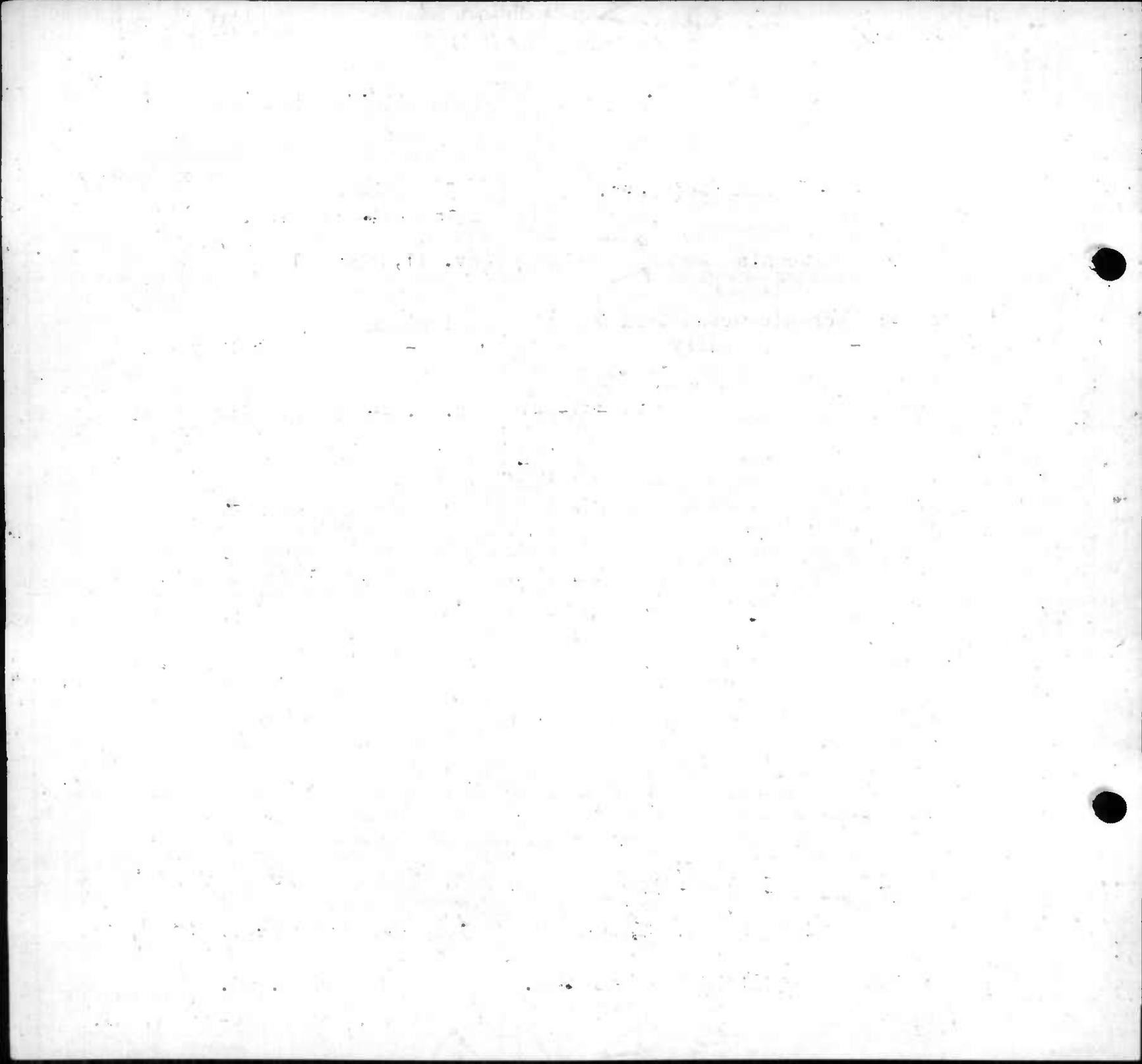
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08238	
BIRTH NO. 72 08238				STATE OF MARYLAND - DHMH	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>JOSEPH S. DUFFY</b>			2. DATE AND HOUR OF DEATH <b>Aug. 28, 1972</b> <b>6:00 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2806 Inglewood Ave.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2757</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>2806 Inglewood Ave.</b>		
5. SEX <b>male</b>	6. RACE <b>caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1890</b>		9. AGE (In years last birthday) <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Master Mechanic Crown Cork &amp; Seal</b>			11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Duffy</b>			14. MOTHER'S MAIDEN NAME <b>Sylvey</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-01-0210</b>	17. INFORMANT <b>Wm. W. Duffy 1301 Airline Way</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease - Angina Pectoris</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 15</b> 19 <b>70</b> to <b>Aug 28</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>May 15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Donald W. Mintzer</b>				23B. DATE SIGNED <b>Aug 28/1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Donald W. Mintzer</b>				23D. ADDRESS <b>3009 Evergreen Ave., Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/31/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem.</b>	
24D. LOCATION <b>Balto, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>			
25B. NAME OF REGISTRAR <b>Leonard J. Ruck</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc-Balto, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-622		72 08239		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08299	
BIRTH NO.		Marten		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) GRACE GORSUCH				2. DATE AND HOUR OF DEATH Aug. 27, 1972. 8:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  2904 Gibbons Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2904 Gibbons Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 21, 1894	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel M. Selden				14. MOTHER'S MAIDEN NAME Emma Bland			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-9976		17. INFORMANT Mrs. Jane W. Shepard		ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE Heart Failure DUE TO, OR AS A CONSEQUENCE OF:			
				(B) Hypertensive Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Several years</u> 19 to 19, that (I) (we) last saw the deceased alive on <u>2-3 months</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Amber...</i>				23B. DATE SIGNED 8-28-72		23C. PHYSICIAN'S NAME (Type) HOMERITO V. CERTEA M.D.	
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23C. PHYSICIAN'S NAME (Type)	
23A. SIGNATURE				23D. ADDRESS 1206 ...		23E. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/30/72		24C. NAME OF CEMETERY OR CREMATORY Moreland Mem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 30 1972		25B. NAME OF REGISTRAR <i>Sidney...</i>		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214	

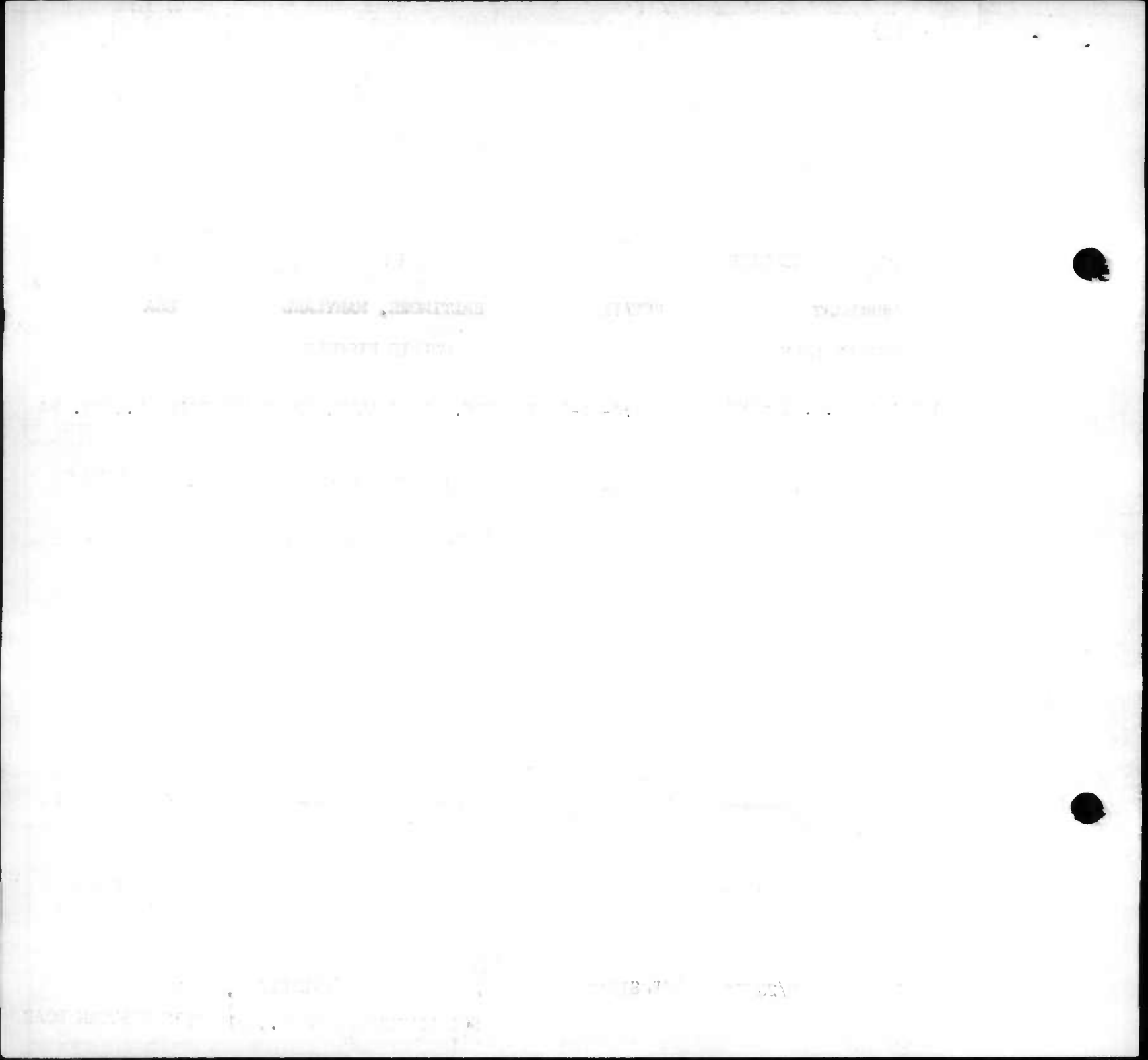


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-100		72 08300		BALTIMORE CITY HEALTH DEPARTMENT		72 08300	
CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <u>Irving LEELEVY</u>				2. DATE AND HOUR OF DEATH <u>8/27/72</u> <u>1 50</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>28 Warren Park Dr.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/29/99</u>	9. AGE (In years last birthday) <u>73</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BARNEY LEVY</u>				14. MOTHER'S MAIDEN NAME <u>GOLDIE FISCHER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES <input checked="" type="checkbox"/> X W.W. I NAVY		16. SOCIAL SECURITY NO. <u>214-01-3607</u>		17. INFORMANT ADDRESS <u>MRS. MINNA LEVY, 28 WARREN PARK DR., APT. B4</u>			
18. <u>446.51</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>20 days</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>8/27/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> <u>19 72</u> to <u>8/27</u> <u>19 72</u> that (I) (we) last saw the deceased alive on <u>8/27</u> <u>19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Karen M. Lichtenfeld MD</u>				23B. DATE SIGNED <u>8/27/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Karen M. Lichtenfeld MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>8/28/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>HAR SINAI</u>	
24D. LOCATION (City, town, or county) (State) <u>REISTERSTOWN, MARYLAND</u>				25A. DATE REC'D BY HEALTH DEPT. <u>AUG 30 1972</u>			
25B. NAME OF REGISTRAR <u>Sol Levinson</u>				25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-100		72 08301		BALTIMORE CITY HEALTH DEPARTMENT		72 08301	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MORRIS YAFFE</b> (MAURICE A. YOFFE)				2. DATE AND HOUR OF DEATH <b>8/26/72 7:40 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>SINAI HOSP. OF BALT., INC.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2831</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSP. OF BALT., INC.</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/6/05</b> 9. AGE (In years last birthday) <b>67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUTTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BENJAMIN YAFFE</b>				14. MOTHER'S MAIDEN NAME <b>YETTA SHERMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-03-8308A</b>		17. INFORMANT ADDRESS <b>MRS. FRED A. YAFFE, 4204 LABYRINTH RD. #21215</b>			
18. CAUSE OF DEATH <b>4/10/9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>ARTERIOSCLEROTIC HEART DISEASE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <b>8/25 1972</b> to <b>8/26 1972</b> that (H) (we) last saw the deceased alive on <b>8/26 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature] Sunshine MD.</b>				23B. DATE SIGNED <b>8/26/72</b>		23C. PHYSICIAN'S NAME (Type) <b>IAN SUNSHINE MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/28/72</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH EL MEMORIAL PARK</b>		24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08302		72 08302	
7-500		72 08302		72 08302	
BIRTH NO.		72 08302		72 08302	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO. STATE OF MARYLAND-DEPT	
FINE, (JACK) JACOB		8-26-72 1:50 P.M.		72 08302	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2755	
Levindale Hebrew Geriatric Center and Hospital		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
91		E. STREET AND NUMBER 5930 GREENMEADOW PKWY. #21209			
5. SEX male		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 7-17-05	
CLERK		GOVERNMENT		9. AGE (In years last birthday) 67	
13. FATHER'S NAME LOUIS FINE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. POLLY KJAFPE, 1326 FARMDALE ST. FLORIDA 33936	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 348.0 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 8/26/72 to 8/26/72 and that (we) last saw the deceased alive on 8/26/72 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.		23A. SIGNATURE Robert G. Gough, M.D.		23B. DATE SIGNED 8/26/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8/28/72		24C. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. AUG 30 1972		25B. NAME OF REGISTRAR Sidney H. Hinton	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS		25E. DATE SIGNED	

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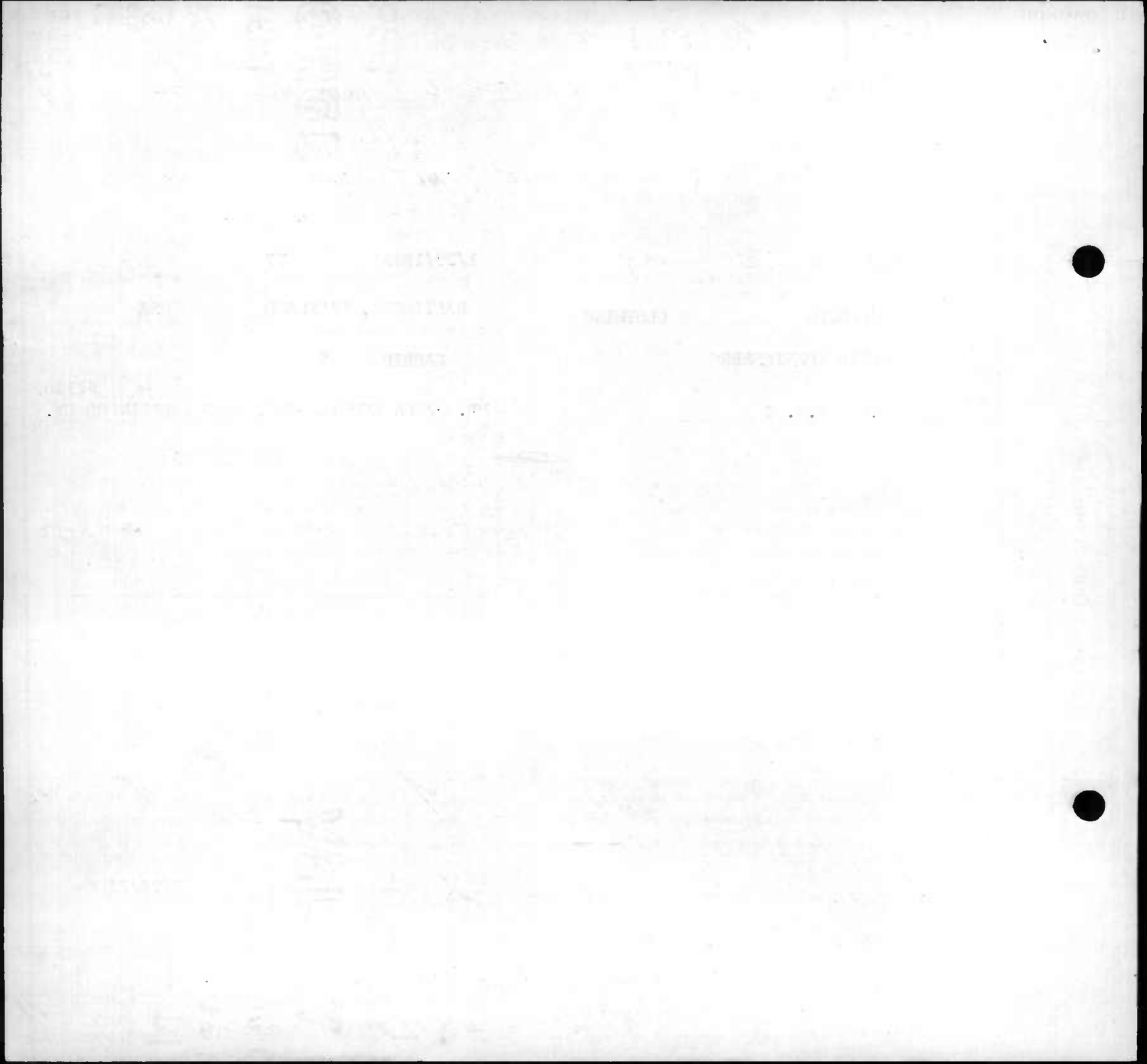
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08303
CERTIFICATE OF DEATH				REG. NO. 72 08303
BIRTH NO. <b>K-521</b>		72 08303		
1. NAME OF DECEASED (Type or Print) <b>SAUL (Sol.) SOLOMON KOENIGSBERG</b>		2. DATE AND HOUR OF DEATH <b>THURS AUG. 24/72 1:45 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 6905 PARK HEIGHTS AVE</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>27 30</b>		
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>6423 ELRAY DRIVE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/29/1895</b>	9. AGE (In years last birthday) <b>77</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>DAVID KOENIGSBERG</b>		
14. MOTHER'S MAIDEN NAME <b>CARRIE ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W. I</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. AARON KOENIGSBERG, 2803 LAURELWOOD CT. #21209</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.9 I</b>		CAUSE OF DEATH <b>Acute Myocardial Infarction</b>		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>My</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>II</b>		(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>7/25/72</b> to <b>8/24/72</b> and that (I) (we) last saw the deceased alive on <b>7/25/72</b> and that in <b>my</b> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
23A. SIGNATURE <b>Harvey Feuerman</b> OEGREE				23B. DATE SIGNED <b>8/24/72</b>
23C. PHYSICIAN'S NAME (Type) <b>HARVEY FEUERMAN</b> OEGREE				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Aug 25</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>
24D. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>		(State)		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Dudley Johnson</b>		25C. FUNERAL DIRECTOR <b>SO &amp; KEVINSON - BOOS INC</b>
ADDRESS <b>5019 Rd</b>				

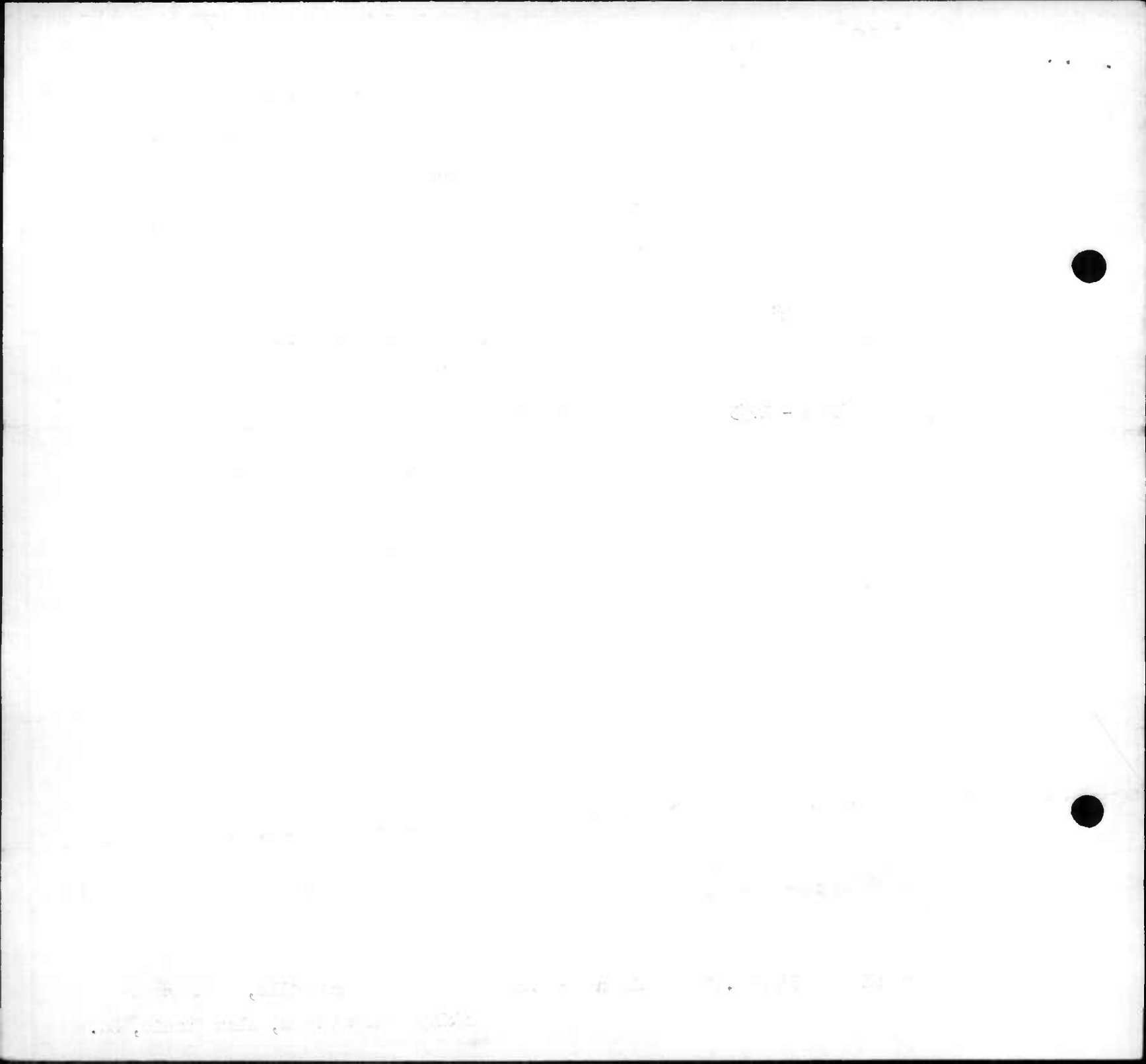




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08304		72 08304	
BIRTH NO.		S-535		72 08304	
1. NAME OF DECEASED (Type or Print)		MILDRED SHENTON		2. DATE AND HOUR OF DEATH 8/28/72 2:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND ANNE ARUNDEL'S		5. SEX F.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BONSECOURS HOSP.		C. CITY OR TOWN GLEN BURNIE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1218 WILSON RD		6. RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3/15/21		9. AGE (In years last birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. U.S. ARMY	
11. BIRTHPLACE (State or foreign country) TENN.		12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME WALTER D. MOONER	
14. MOTHER'S MAIDEN NAME JOSEPHINE HARTMAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES 1944 - 1953		16. SOCIAL SECURITY NO. 408-24-8241	
17. INFORMANT NORMAN SHENTON 1218 WILSON RD GLEN BURNIE, MD		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) METASTATIC CA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION		19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE [Signature]	
23B. DATE SIGNED 8-28-72		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 31 Aug. 72		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Nashville, Tennessee		25A. DATE REC'D BY HEALTH DEPT. AUG 30 1972		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25D. ADDRESS		25E. DATE	



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72 08305 BALTIMORE CITY HEALTH DEPARTMENT

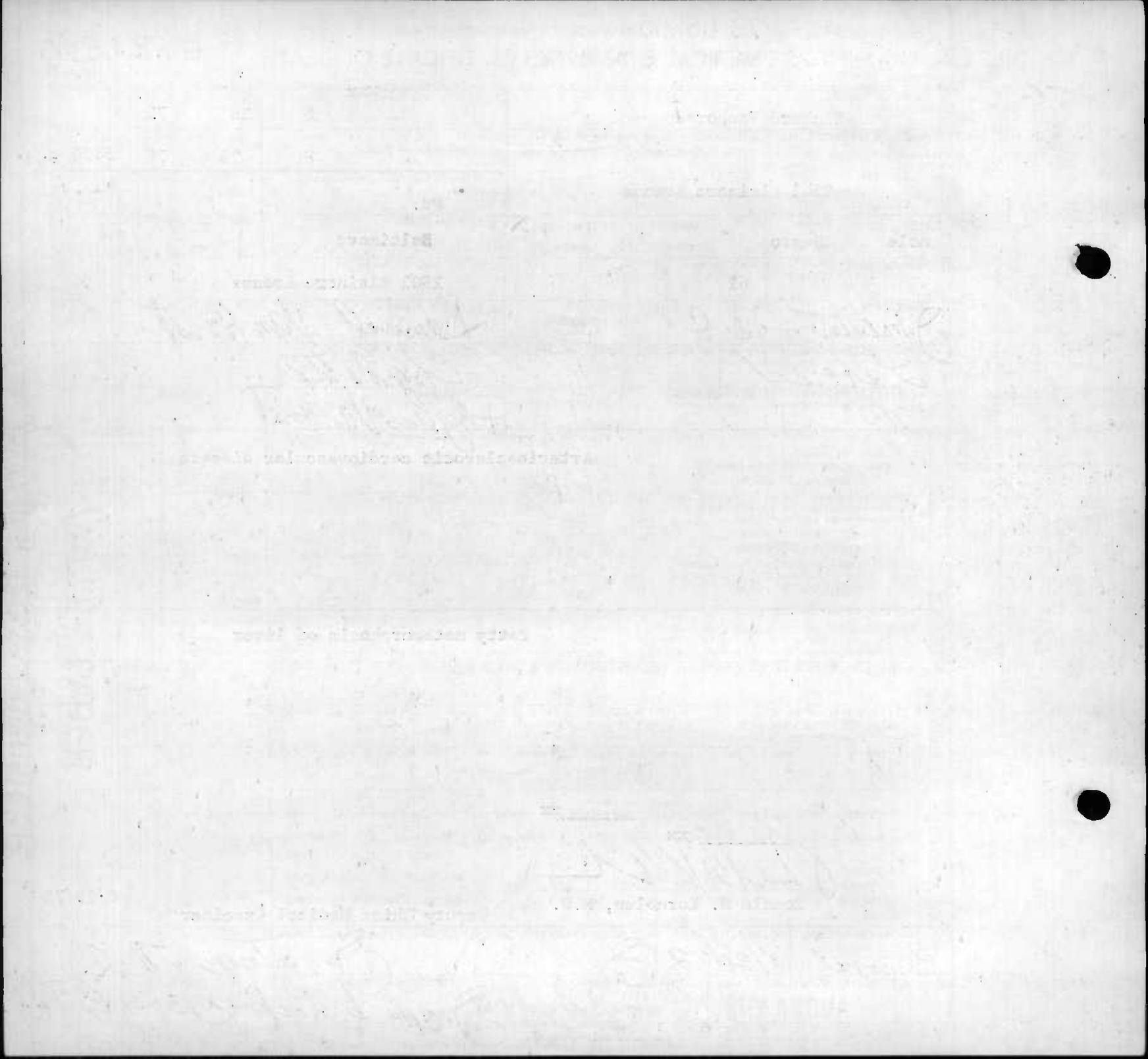
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08305

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Richard Vanhorne</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>8</b> Day <b>28</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>2502 Elsinore Avenue</b>		3. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>28</b> Year <b>72</b> Hour <b>5:50 p.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1538</b>	
9. DATE OF BIRTH <b>62</b>		10. AGE (In years last birthday) <b>62</b>	
11. BIRTHPLACE (State or foreign country) <b>Samuelson, S. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Van Horst</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Latimer</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Fatty metamorphosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>8/30/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/29/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>8/30/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>W.C.</b>		24D. LOCATION (City, town, or county) (State) <b>W.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnson</b>	
25C. FUNERAL DIRECTOR <b>Joseph P. Lock</b>		ADDRESS <b>1304 N. Central Ave</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louden Aye				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 24 Year 72 Hour 12:52 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital				3. DATE PRONOUNCED DEAD Month 8 Day 24 Year 72 Hour 12:52 P.M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-13-43				10. AGE (in years lost birthday) 28		11. BIRTHPLACE (State or foreign country) Baltimore, MD	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Wan Aye Sr		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
15. MOTHER'S MAIDEN NAME Janie Robinson				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-42-2874	
18. INFORMANT Janie Aye				ADDRESS 4006 Duval Ave		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of chest				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2200 blk of Division St.	
22D. TIME OF INJURY (APPROX.) 8 24 72 12:35 P.M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William P. Mulloy, M.D.				DATE SIGNED 8-25-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8-28-72		24C. NAME OF CEMETERY or CREMATORY Maryland National Memorial - Laurel, MD	
25A. DATE REC'D BY HEALTH DEPT. AUG 30 1972				25B. NAME OF REGISTRAR Sidney H. Hinton		25C. FUNERAL DIRECTOR Glenston S. Phillips - 1721 N. Moore St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

*Dear ges. 1*

**S-530** **72 08307** **CERTIFICATE OF DEATH** **BALTIMORE CITY HEALTH DEPARTMENT** **REG. NO. 72 08307** **STATE OF MARYLAND-DEATH**

**BIRTH NO.** **1. NAME OF DECEASED** **2. DATE AND HOUR OF DEATH**

**SMITH, LAURETTA MAE** **AUGUST 25, 1972** **3:20 A.M.**

**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD** **4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)**

**ST. AGNES HOSPITAL** **MARYLAND**

**5. SEX** **6. RACE** **7. MARRIED** **8. DATE OF BIRTH** **9. AGE (In years last birthday)** **10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)** **11. BIRTHPLACE (State or foreign country)** **12. CITIZEN OF WHAT COUNTRY?**

**FEMALE** **NEGRO** **NEVER MARRIED** **12/05/12** **59** **MARYLAND** **U.S.A.**

**13. FATHER'S NAME** **14. MOTHER'S MAIDEN NAME**

**JAMES DOUGHERTY** **MARY (MINNIS)**

**15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)** **16. SOCIAL SECURITY NO.** **17. INFORMANT** **ADDRESS**

**217-38-5444** **ST. AGNES' RECORDS** **BALTIMORE, MARYLAND 21229**

**18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** **CAUSE OF DEATH** **APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH**

**Massive Stenosis** **8 hrs**

**(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:**

**Severe acidosis, prob**

**(B) DUE TO, OR AS A CONSEQUENCE OF:**

**ble lactic** **24 hrs**

**(C) DUE TO, OR AS A CONSEQUENCE OF:**

**Dehydration -** **?**

**II**

**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).**

**Diabetes mellitus**

**Generalized coronary atherosclerosis**

**19A. DATE OF OPERATION** **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **20A. AUTOPSY? (Yes or No)** **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?**

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)** **21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)** **21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)**

**21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)** **21E. INJURY OCCURRED** **21F. HOW DID INJURY OCCUR?**

**22. I certify that (X) (this hospital) attended the deceased from AUGUST 24, 19 72 to AUGUST 25, 19 72, that (X) (we) last saw the deceased alive on AUGUST 25, 19 72 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.**

**23A. SIGNATURE** **23B. DATE SIGNED**

**23C. PHYSICIAN'S NAME (Type)** **23D. ADDRESS**

**JOSE APTER MD.** **CATON & WILKENS AVENUE**

**24A. BURIAL CREMATION, REMOVAL (Specify)** **24B. DATE** **24C. NAME OF CEMETERY OR CREMATORY** **24D. LOCATION (City, town, or county) (State)**

**Burial** **8-28-72** **Cedar Hill** **Baltimore, MD**

**25A. DATE REC'D BY HEALTH DEPT.** **25B. NAME OF REGISTRAR** **25C. FUNERAL DIRECTOR** **ADDRESS**

**AUG 30 1972** **Sidney B. H. H. H.** **Phillips Funeral Home - 1221-27 N. Monroe St**

VS 150-REV. 1/1/68



15

UNITED STATES DEPARTMENT OF JUSTICE

August 22, 1954

Washington, D.C.

Mr. Tolson

Mr. E. A. Tamm

Mr. J. Edgar Hoover

Mr. Clegg

Mr. Glavin

Mr. Ladd

Mr. Nichols

Mr. Rosen

Mr. Tracy

RE: JAMES EARL RAY, AKA  
ET AL; MURDER OF MARTIN LUTHER KING, JR.

August 22, 1954

August 22, 1954

August 22, 1954

XXXX

XXXX

August 22, 1954

NOTED & FILED

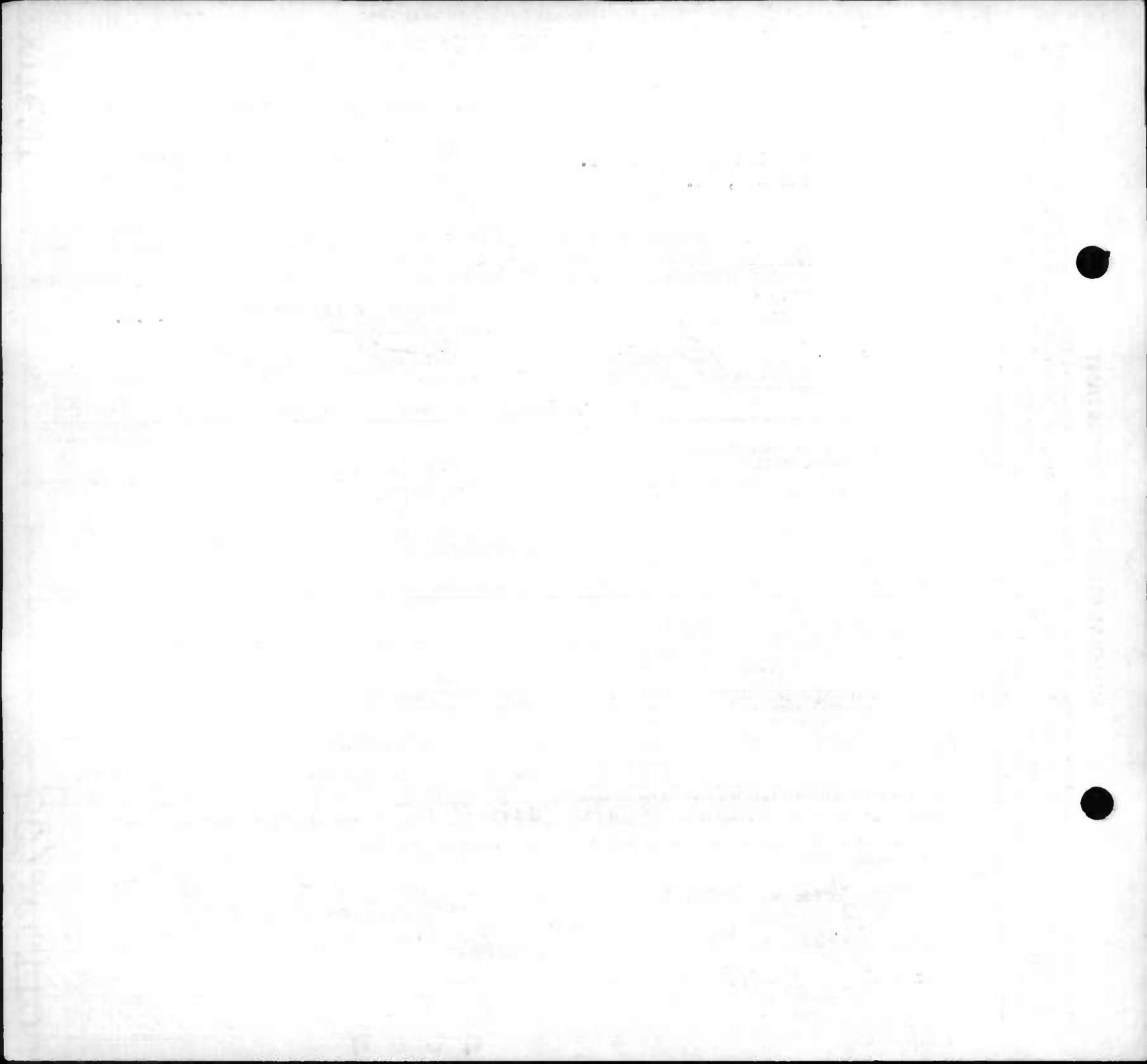
August 22, 1954

James Earl Ray, AKA  
Murder of Martin Luther King, Jr.  
August 22, 1954

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08308</u>
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMD
W-426 <u>72 08308</u>				
BIRTH NO.		DATE AND HOUR OF DEATH <u>8/24/72</u> <u>2:50 P.M.</u>		
1. NAME OF DECEASED (Type or Print) <u>WALKER, LOUVENIA</u>		2. DATE AND HOUR OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>PROVIDENT HOSPITAL</u>		A. STATE <u>MARYLAND</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>		B. COUNTY <u>2002</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>2110 W. VINE ST</u>		
5. SEX <u>F</u>	6. RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-41</u>	9. AGE (in years last birthday) <u>31</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Julius Bogier</u>		14. MOTHER'S MAIDEN NAME <u>Nattie Vaughn</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-7442</u>		17. INFORMANT <u>HUSBAND - CLINTON WALKER - SAME</u>
18. <u>2600 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>SEVERE KETOACIDOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>SEVERE DEHYDRATION</u> <u>DIABETIC COMA</u> (B) <u>UNCONTROLLED DIABETES MELLITUS - 2 months</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>8/24/72</u> <u>2:50 P.M.</u> to <u>8/24</u> <u>3:50 P.M.</u> 19 <u>72</u> and that (I) (we) last saw the deceased alive on <u>8/24/72</u> <u>2:45 P.M.</u> 19 <u>72</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Ma. Elena V. Manlay</u> M.D.		23B. DATE SIGNED <u>8/24/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>MA. ELENA V. MANLAY</u> M.D.		23D. ADDRESS <u>PROVIDENT HOSPITAL</u> <u>2600 LIBERTY HTS. BALTO. MD 21215</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/27/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>
24D. LOCATION <u>Baltimore</u>		(City, town, or county) (State) <u>MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 30 1972</u>		25B. NAME OF REGISTRAR <u>A. J. H. H. H.</u>		25C. FUNERAL DIRECTOR <u>William J. Phillips</u>
				ADDRESS <u>1727 N. Mount St.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

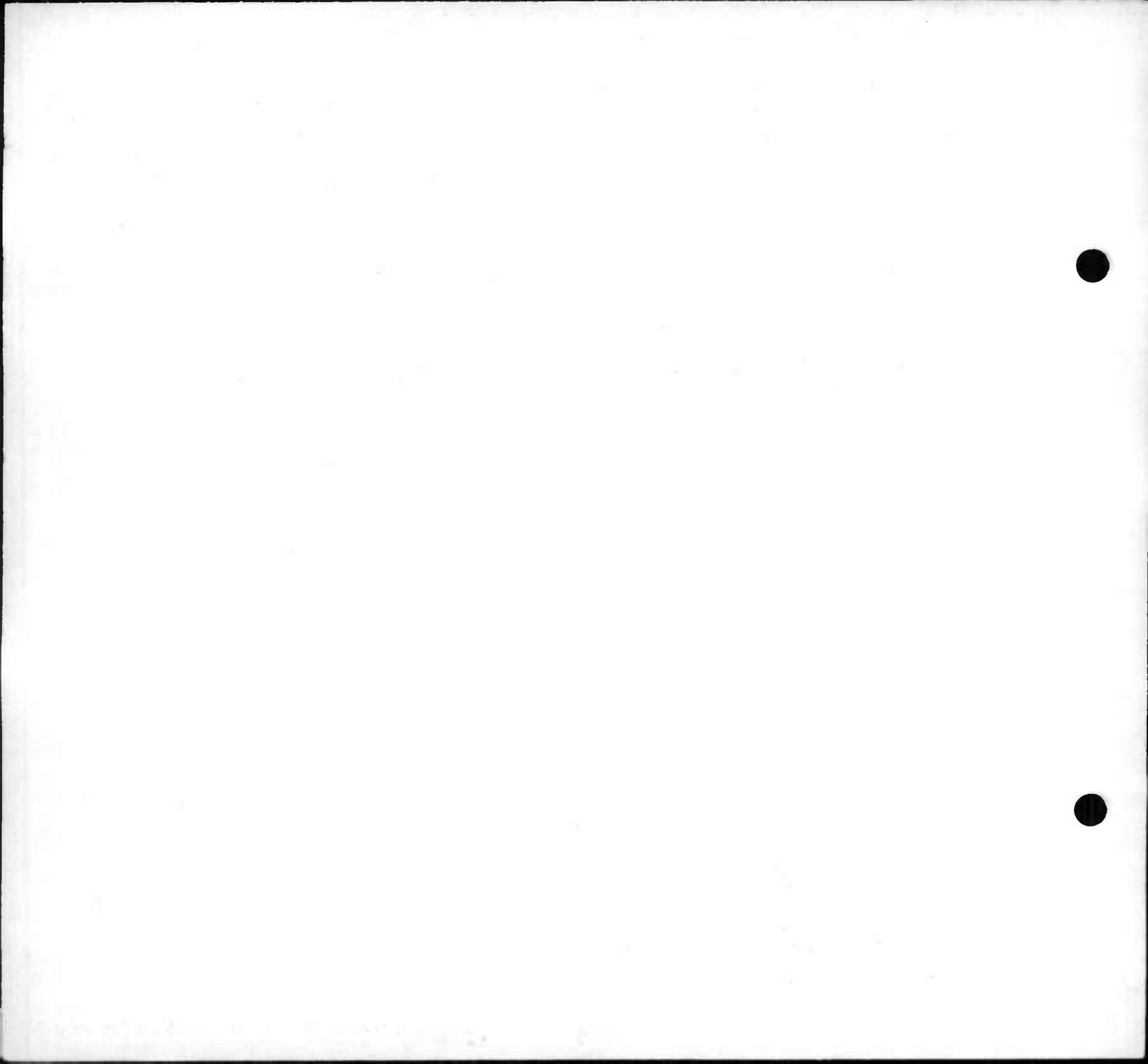
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 08309 STATE OF MARYLAND-DEHM
1. NAME OF DECEASED (Type or Print) <b>MESZAROS, Mrs MARGARET</b>		2. DATE AND HOUR OF DEATH <b>8/28/72 2:00 P</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home Hospital.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND - BALTIMORE</b> B. COUNTY <b>city.</b> C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1936 E. BANK ST. 21231</b>		
5. SEX <b>F.</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07/11/18</b>	9. AGE (In years last birthday) <b>54</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		13. FATHER'S NAME <b>JOHN SMITH</b>		
14. MOTHER'S MAIDEN NAME <b>CATHERINE Barkowicz</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>212 102566</b>		17. INFORMANT ADDRESS <b>Harry Meszaros Sr. 1936 Bank Street</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute RENAL FAILURE ANURIA.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>UREMIA &amp; ANEMIA.</b> <b>DIABETES MELLITUS.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSION - A.C.U.D.</b> (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>8/27/72</b> to <b>8/28/72</b> 19 that (I) (we) last saw the deceased alive on <b>8/28/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Walker, IMPATILITELLI</b>		23B. DATE SIGNED <b>8/28/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Walker, IMPATILITELLI</b>
23D. ADDRESS <b>180 N. Broadway St. Church Home Hosp.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9-1-1972</b>	24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>	25B. NAME OF REGISTRAR <b>Sidney...</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Milly &amp; Zeller Inc. 1901-07 Eastern Ave.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-635		72 08310		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08310	
BIRTH NO.				STATE OF MARYLAND - DHMH			
1. NAME OF DECEASED (Type or Print) <u>Gordon Richard J.</u>				2. DATE AND HOUR OF DEATH <u>8 128 1972</u> <u>11 33</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Good Samaritan Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Baltimore Maryland</u> B. COUNTY <u>1607</u> C. CITY OR TOWN <u>2921 Winchester Street</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER			
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-22-20</u>	9. AGE (In years lost birthday) <u>52</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>S.C.</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Gordon George</u>			
14. MOTHER'S MAIDEN NAME <u>McFadden, Bessie</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>214-05-1412</u>				17. INFORMANT <u>GLADYS GORDON 2921 WINCHESTER ST</u>			
18. <u>16211</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>None</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u> 20A. AUTOPSY? (Yes or No) <u>None</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>None</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>None</u> 22. I certify that (I) (this hospital) attended the deceased from <u>August 25</u> 19 <u>72</u> to <u>August 28</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>August 28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE <u>J.H. Varnell Jr.</u> 23B. DATE SIGNED <u>8/28/72</u> 23C. PHYSICIAN'S NAME (Type) <u>J.H. Varnell Jr. - M.D.</u> 23D. ADDRESS <u>1505 East Monument Street. Balt Md</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 24B. DATE <u>9-1-72</u> 24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE CEMETERY BALTO. M.D.</u> 24D. LOCATION (City, town, or county) (State) <u>BALTO. M.D.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>AUG 30 1972</u> 25B. NAME OF REGISTRAR <u>Sidney Whitman</u> 25C. FUNERAL DIRECTOR <u>W.B. C. MARCH</u> 25D. ADDRESS <u>928 E NORTH AVE</u>							





B-400

72 08311 STATE OF MARYLAND-DEME  
BALTIMORE CITY HEALTH DEPARTMENT

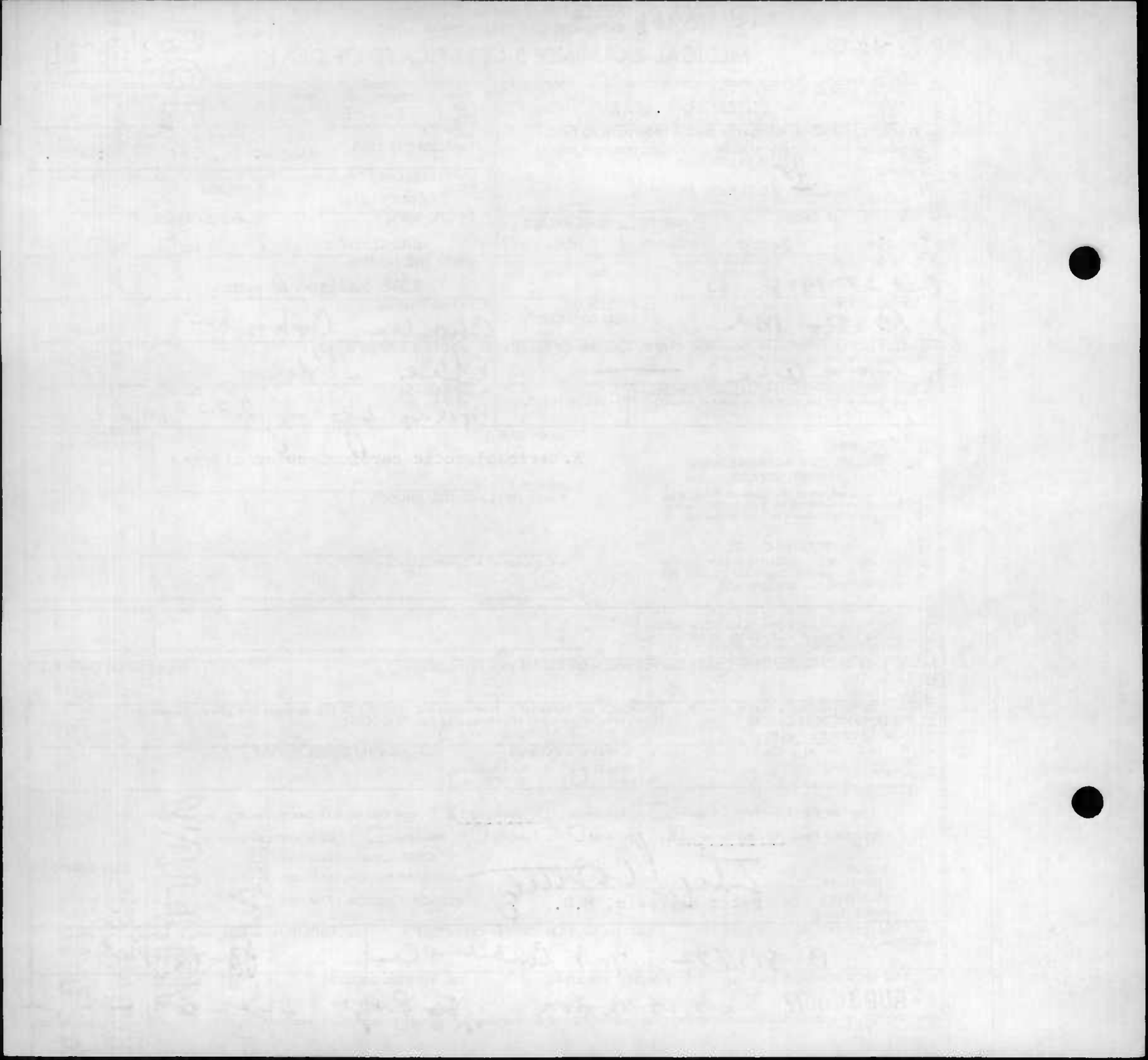
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08311

BIRTH NO.

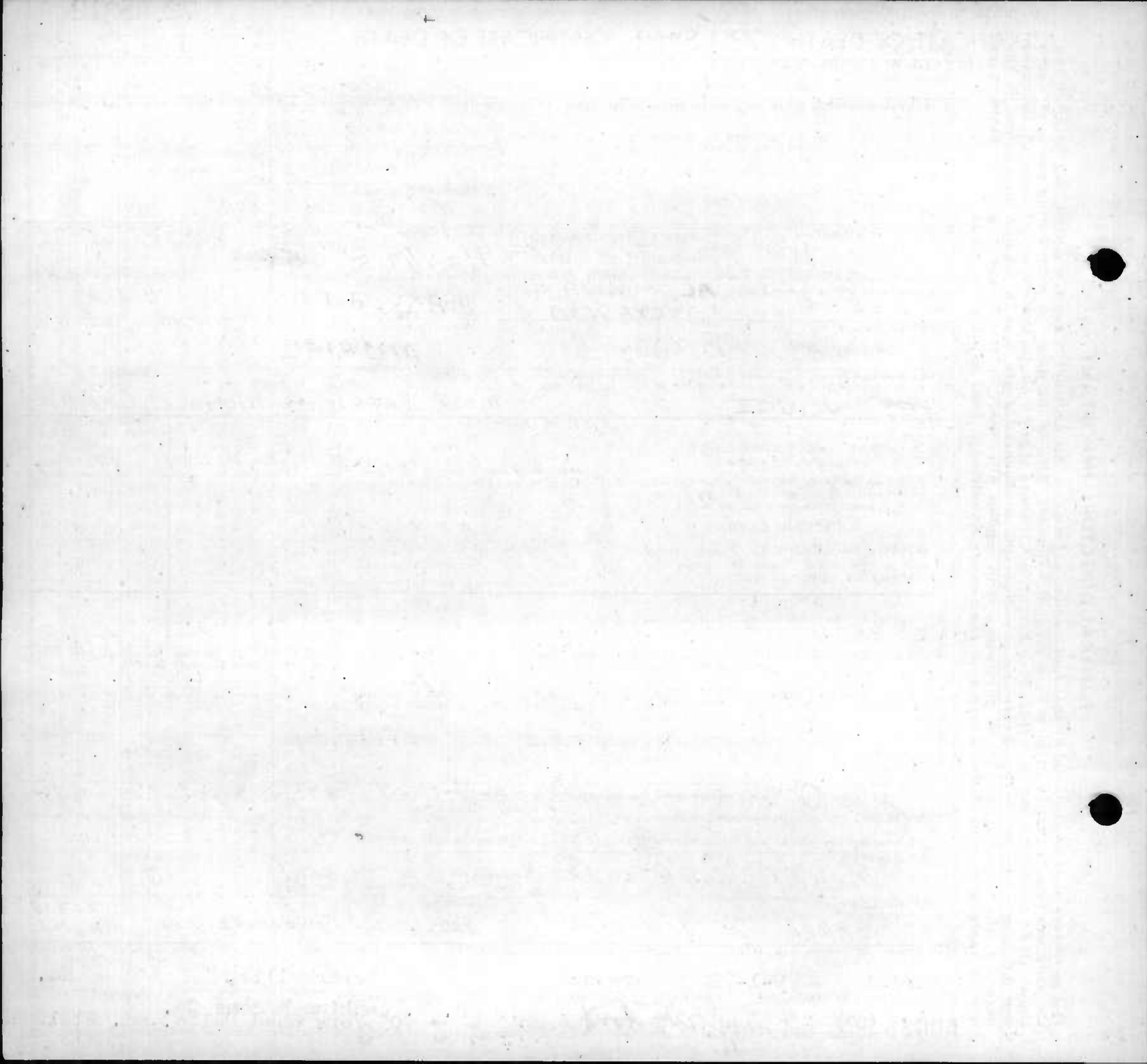
1. NAME OF DECEASED (Type or Print) <b>FLORENCE E. BAILEY</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2284 Madison Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 26, 1972 9:00 A.</b> M.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Oct 25 1908</b>		10. AGE (In years last birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Effie Lyles</b>	
15. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1303</b>		E. STREET AND NUMBER <b>2248 Madison Avenue</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Hilde York</b>		ADDRESS <b>2307 Madison</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22H. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 27, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>8/31/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>mt Auburn Ce</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>		25B. NAME OF REGISTRAR <b>Lidney</b>	
25C. FUNERAL DIRECTOR <b>2222 W. 101st Ave</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

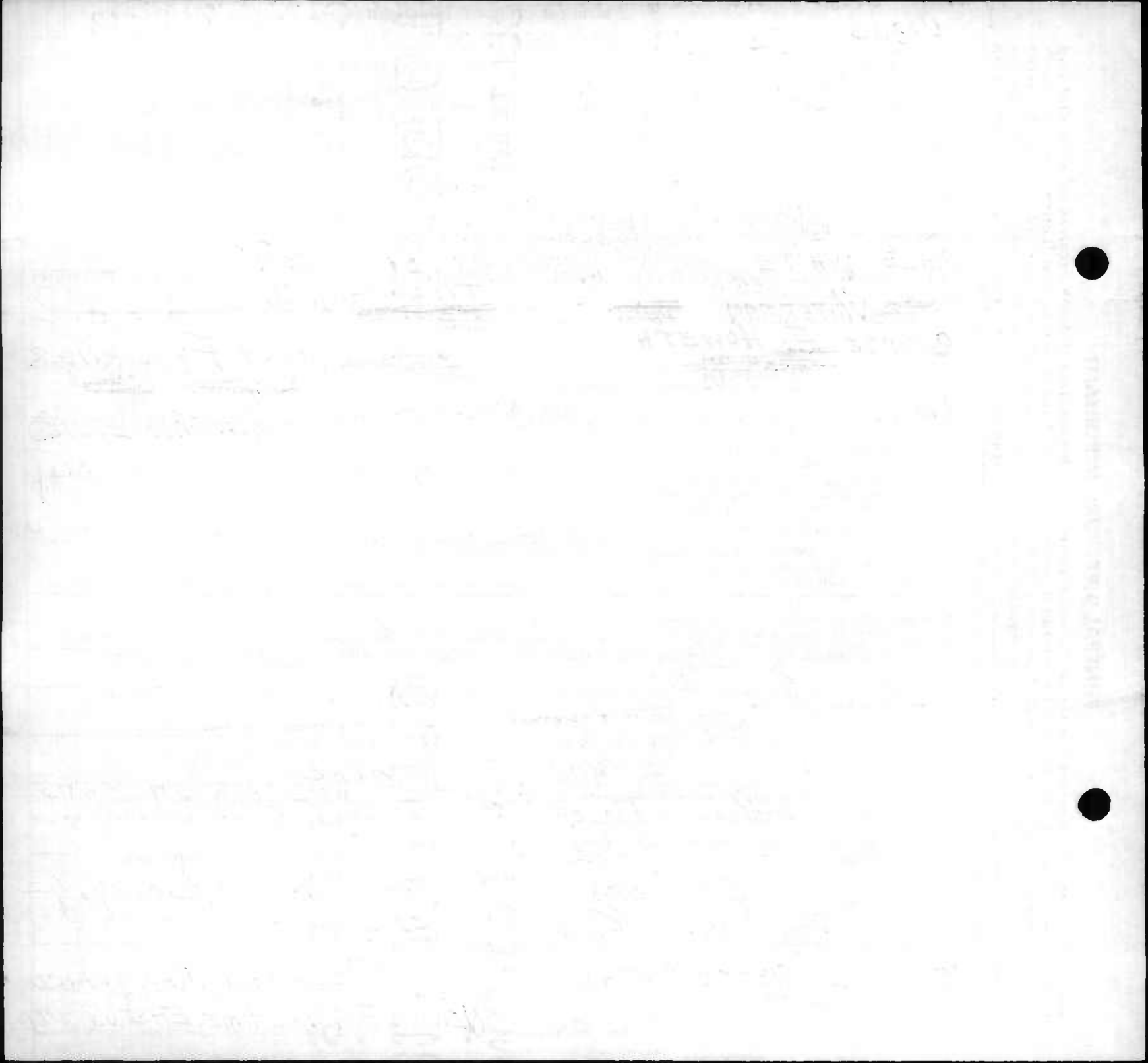
X-620		72 08312		CITY HEALTH DEPARTMENT		REG. NO. 72 08312	
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) MURIEL B. KERSEY				2. DATE AND HOUR OF DEATH 08.29.72 10.30 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL 44				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND, U.S.A. 905 B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 708 GOR SUCH AVE.			
5. SEX F	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1915	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK			10B. KIND OF BUSINESS OR INDUSTRY ALEXANDRA & ALEXANDRA		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME BRADY			14. MOTHER'S MAIDEN NAME MURIEL				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MISS PATRICIA McHALL (SAME)		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION 17 days.		(B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D. 10 years.	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 24 1972 to August 29 1972, that (I) (we) last saw the deceased alive on August 29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 08/29/72	
23C. PHYSICIAN'S NAME (Type) CARLOS H. SANTILLAN				23D. ADDRESS THE UNION MEMORIAL HOSP; Ba, Md. 21218.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-1-72		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Parkville, Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 30 1972		25B. NAME OF REGISTRAR Sidney W. [Signature]		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 34905 York Road Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-300		72 08313		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08313	
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <u>Albert J. Howeth</u>				2. DATE AND HOUR OF DEATH <u>Aug. 27, 1972</u> <u>8:35 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2403</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>S.B.G.H. (South Baltimore General Hospital)</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1001 Light St.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/4/80</u>	9. AGE (In years last birthday) <u>90</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TILGHMAN, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE E. HOWETH</u>				14. MOTHER'S MAIDEN NAME <u>MARY FAULKNER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-1367-A</u>		17. INFORMANT <u>Mrs. Kaplan</u> ADDRESS <u>13307 Olympia Ave. BALTIMORE</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>one day</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bacteremia</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Penile Carcinoma with metastasis over one year</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>arteriosclerosis</u>							
19A. DATE OF OPERATION <u>Aug. 27, 1972</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>poor</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>none</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>none</u>		21C. WHERE DID INJURY OCCUR? <u>none</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>none</u>		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> <u>none</u>		21F. HOW DID INJURY OCCUR? <u>none</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 25</u> 19 <u>72</u> to <u>Aug. 27</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug. 27</u> 19 <u>72</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Phel Woo Song</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Aug. 27, 72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Phel Woo Song</u>				23D. ADDRESS <u>S.B.G.H.</u>			
24A. SURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/30/72</u>		24C. NAME of CEMETERY or CREMATORY <u>METHODIST</u>		24D. LOCATION (City, town, or county) (State) <u>TILGHMAN, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 30 1972</u>		25B. NAME OF REGISTRAR <u>John H. Hinton</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NEWMAN FUNERAL HOME, EASTON, MD.</u>			





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BALTIMORE CITY HEALTH DEPARTMENT						72 08314	
K-256      72 08314      CERTIFICATE OF DEATH						REG. NO.	
BIRTH NO.						STATE OF MARYLAND - DH&H	
1. NAME OF DECEASED (Type or Print) <b>Kesner, May Elizabeth Mae Kesner</b>						2. DATE AND HOUR OF DEATH <b>8-25-72 11:10 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>West Virginia</b> B. COUNTY <b>V45</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Bolton Hill Nursing &amp; Convalescent Center Lafayette &amp; John Street Baltimore, Maryland</b>						C. CITY OR TOWN <b>Wiley Ford, W. Va.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>#one</b>							
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-2-9</b>	
						9. AGE (in years last birthday) <b>63</b>	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Wolfee</b>						14. MOTHER'S MAIDEN NAME <b>Carrie ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>236-36-1528</b>	
17. INFORMANT <b>MRS. Twigg - 2815 Giffen Ave</b>						ADDRESS	
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cancer of uterus</b> <b>Hypertension</b> <b>arteriosclerosis</b>						<b>11/70</b> <b>11/70</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7/28 1972</b> to <b>8/25 1972</b> that (I) (we) last saw the deceased alive on <b>8/25 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>[Signature]</b>						23B. DATE SIGNED <b>8/26/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ananias H. Meacham MD</b>						23D. ADDRESS <b>NE Real St Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-29-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Cumberland, Allegany, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 30 1972</b>				25B. NAME OF REGISTRAR <b>Sidney Thornton</b>		25C. FUNERAL DIRECTOR <b>James F. Scherpelli</b> , Cumberland Md.	



10/1

58-22-2

10/1, 10/2-17

2-10-18

advis. to...  
Robert...  
local... 10/1

22

p-1-4

W

A.B.H.

advis. to...

advis. to...

advis. to...

10/1

10/1

10/1

advis. to...

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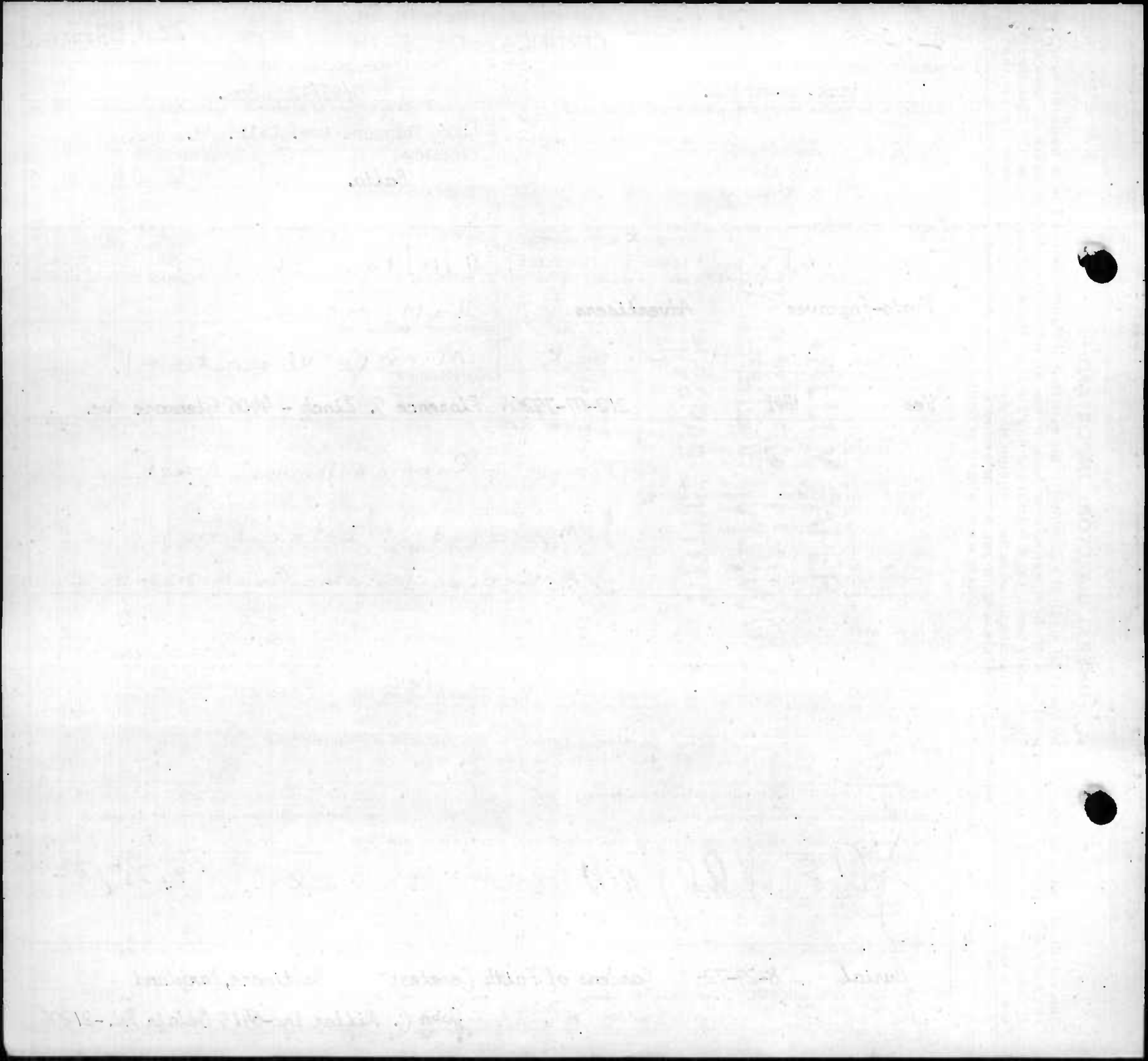
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# FUNERAL DIRECTOR: IMPORTANT

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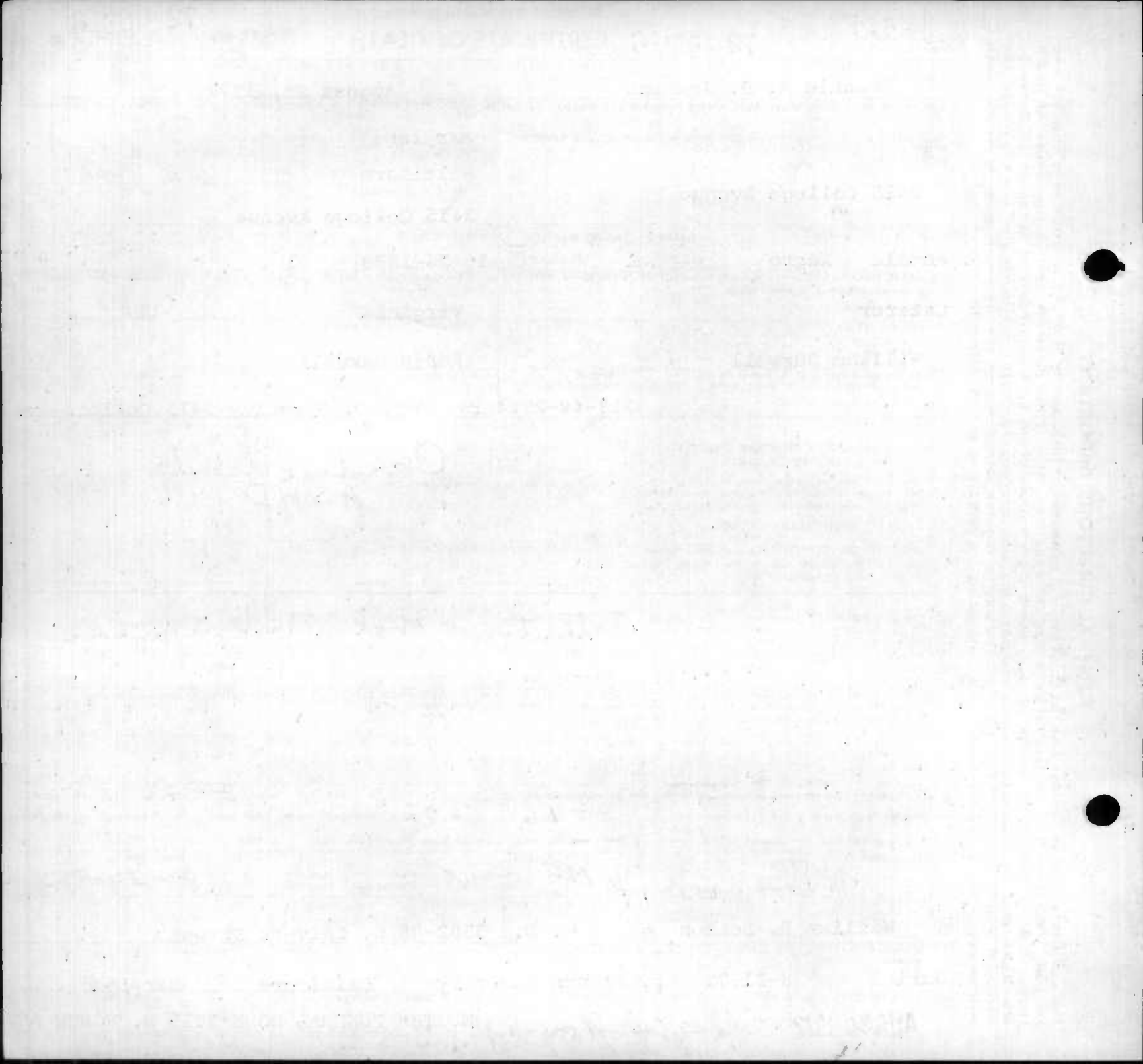
Z-520		72 08315		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08315	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) Zinck, Edward A. Sr.				2. DATE AND HOUR OF DEATH 8/25/72 6pm. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 4406 Glenmore Ave. Balt. Md. 2631			
				C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/11/95	9. AGE (In years last birthday) 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo-Engraver	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY Advertisers		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Charles H. Zinck				14. MOTHER'S MAIDEN NAME Mary Wentzel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. 212-07-7926A		17. INFORMANT ADDRESS Florence J. Zinck - 4406 Glenmore Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerotic Cardiovascular Disease			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 8/25/72		23C. PHYSICIAN'S NAME (Type) [Signature]	
23D. ADDRESS [Signature]				23E. ADDRESS [Signature]		23F. ADDRESS [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 8-29-72		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				24E. DATE REC'D BY HEALTH DEPT. AUG 30 1972		24F. NAME OF REGISTRAR [Signature]	
24G. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206				24H. ADDRESS [Signature]		24I. ADDRESS [Signature]	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08316</u>
72 08316				STATE OF MARYLAND-DEATH
BIRTH NO. <u>J-525</u>		1. NAME OF DECEASED (Type or Print) <u>Fannie A. B. Jenkins</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>2415 College Avenue</u>		2. DATE AND HOUR OF DEATH <u>August 26, 1972</u> M.		
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caterer</u>		8. DATE OF BIRTH <u>10-24-1880</u>		
13. FATHER'S NAME <u>William Burwell</u>		9. AGE (In years last birthday) <u>91</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-48-2924</u>		10. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2733</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Arthritis + Malnutrition</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		
19. DATE OF OPERATION		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
20. AUTOPSY? (Yes or No)		14. MOTHER'S MAIDEN NAME <u>Addie Maxwell</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		15. INFORMANT <u>Mrs. Mary O. Spratley</u> ADDRESS <u>2415 College Ave.</u>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		16. CAUSE OF DEATH <u>Cardiac Arrest</u> <u>ASHD</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		17. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Arthritis + Malnutrition</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>2:30 P.M.</u>		18. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		19. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
22. I certify that (1) (this hospital) attended the deceased from <u>8-26</u> 19 <u>72</u> to <u>8-26</u> 19 <u>72</u> , that (1) (we) last saw the deceased alive on <u>8-26</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		20. DATE OF OPERATION		
23A. SIGNATURE <u>W.P. Benson, Jr. M.D.</u>		21. DATE SIGNED <u>8-29-72</u>		
23C. PHYSICIAN'S NAME (Type) <u>William P. Benson</u>		22. ADDRESS <u>M. D. 3502-06 N. Calvert Street</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23. DATE <u>8-31-72</u>		
24B. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 30 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		
25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u>		25D. ADDRESS <u>3035 W. NORTH AVE</u>		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08317

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Louis A. Williams</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 28 1972 4:15 a</b> M.			
6. SEX <b>male</b>				7. RACE <b>negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>9-14-1921</b>				10. AGE (In years last birthday) <b>50</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Lee Williams</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2037</b>	
15. MOTHER'S MAIDEN NAME <b>Edna Cornish</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-12-8851</b>	
18. INFORMANT <b>Leon J. Williams</b>				19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty infiltration of the liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>			
20A. DATE OF OPERATION <b>8-27-72</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>3</b>			
21. AUTOPSY? (Yes or No) <b>yes</b>				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>(Month) (Day) (Year) (Hour)</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23.			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8-28-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9-1-1972</b>			
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Meorial Park</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT <b>AUG 30 1972</b>				25B. NAME OF REGISTRAR <b>Sidney B. Winton</b>			
25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>				ADDRESS <b>3035 W. NORTH AV</b>			

9-15-1972 - Letter from the office of the Chief Medical Examiner, Russell S. Fisher, M.D.  
Chief Medical Examiner

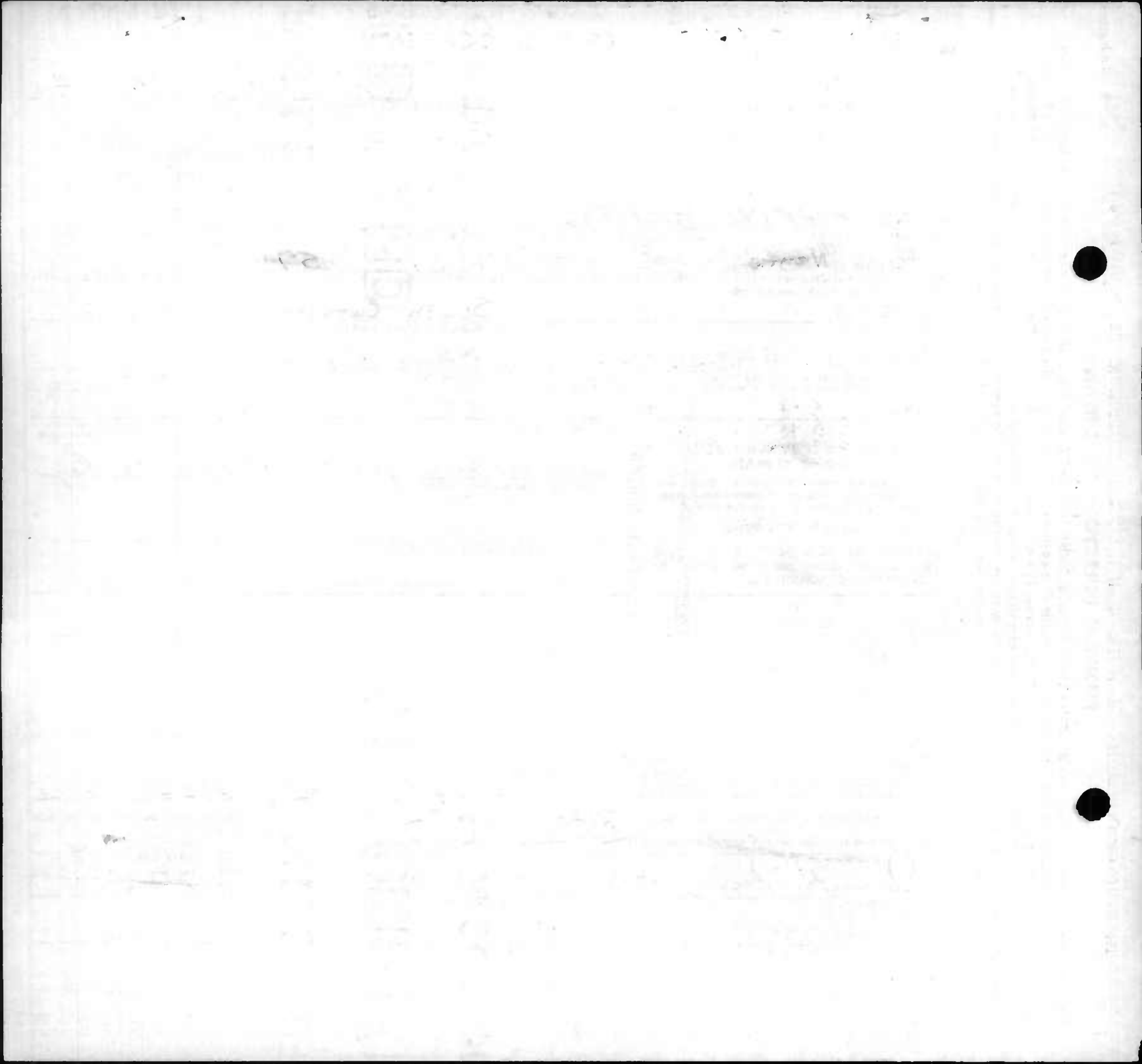
HRS



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
B-650 72-08218				72-08218	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DH&H	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GERTRUDE BROWN		08/26/72 10:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
JOHNS HOPKINS HOSPITAL				MD CITY	
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Female Negro				BALT. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH 9. AGE (In years, last birthday) 58				E. STREET AND NUMBER	
9/13/13 57				525 E. 22nd ST	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
COOK				South Carolina	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
DAVID HARRISON				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME	
NO				MAGGIE DEAN	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
				Bertha Thomas 3235 Canton Ave. Detroit Mich.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				10 days	
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/24 19 72 to 8/26 19 72					
that (I) (we) last saw the deceased alive on 8/26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
James H. Nutter MD				8/26	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JAMES H. NUTTER MD				JOHNS HOPKINS HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		8-31-72		Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
AUG 30 1972		James H. Nutter		NUTTER FUNERAL HOME 3035 W. NORTH AVE.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

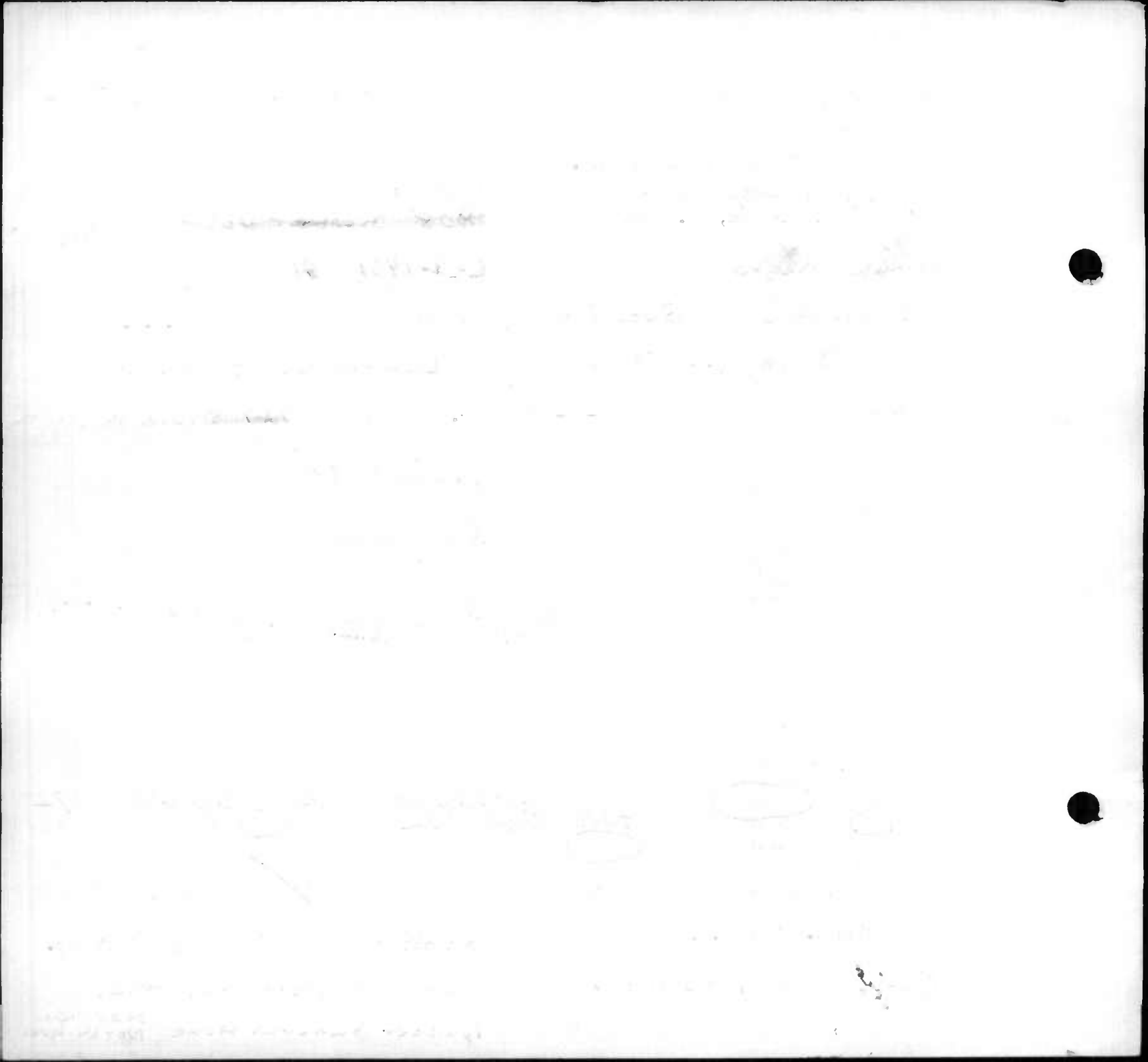
VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08320</u>	
72 08320				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>BARNES, JERELINE</u>		<u>8-23-72</u> <u>6:30</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>2600 Liberty Height Ave.</u> <u>Baltimore, Md. 21215</u>				<u>Maryland</u> C. CITY OR TOWN D. INSIDE CITY LIMITS? <u>Baltimore</u> YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>808 Raser Vair St.</u>	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-1901</u>	9. AGE (In years last birthday) <u>71</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bus. Family</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John W. Thomas</u>			14. MOTHER'S MAIDEN NAME <u>Laura V. Johnson</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-24-5976</u>		17. INFORMANT ADDRESS <u>Mrs. Mildred Blue 727 Druid Rd. Lake Dr.</u>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Dehydration</u> (B) <u>Fecal impaction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4 A.M. Aug 20</u> 19 <u>72</u> to <u>Aug 23</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>4 A.M. Aug 23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Maurice A. Allen, M.D.</u> DEGREE				23B. DATE SIGNED <u>August 23, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Maurice A. Allen M.D.</u>				23D. ADDRESS <u>Provident Hospital 2600 Liberty Height Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-26-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 30 1972</u>		25B. NAME OF REGISTRAR <u>Trinity W. Houston</u>		25C. FUNERAL DIRECTOR <u>Murder Funeral Home</u>	
				ADDRESS <u>3035 W. North Ave.</u>	

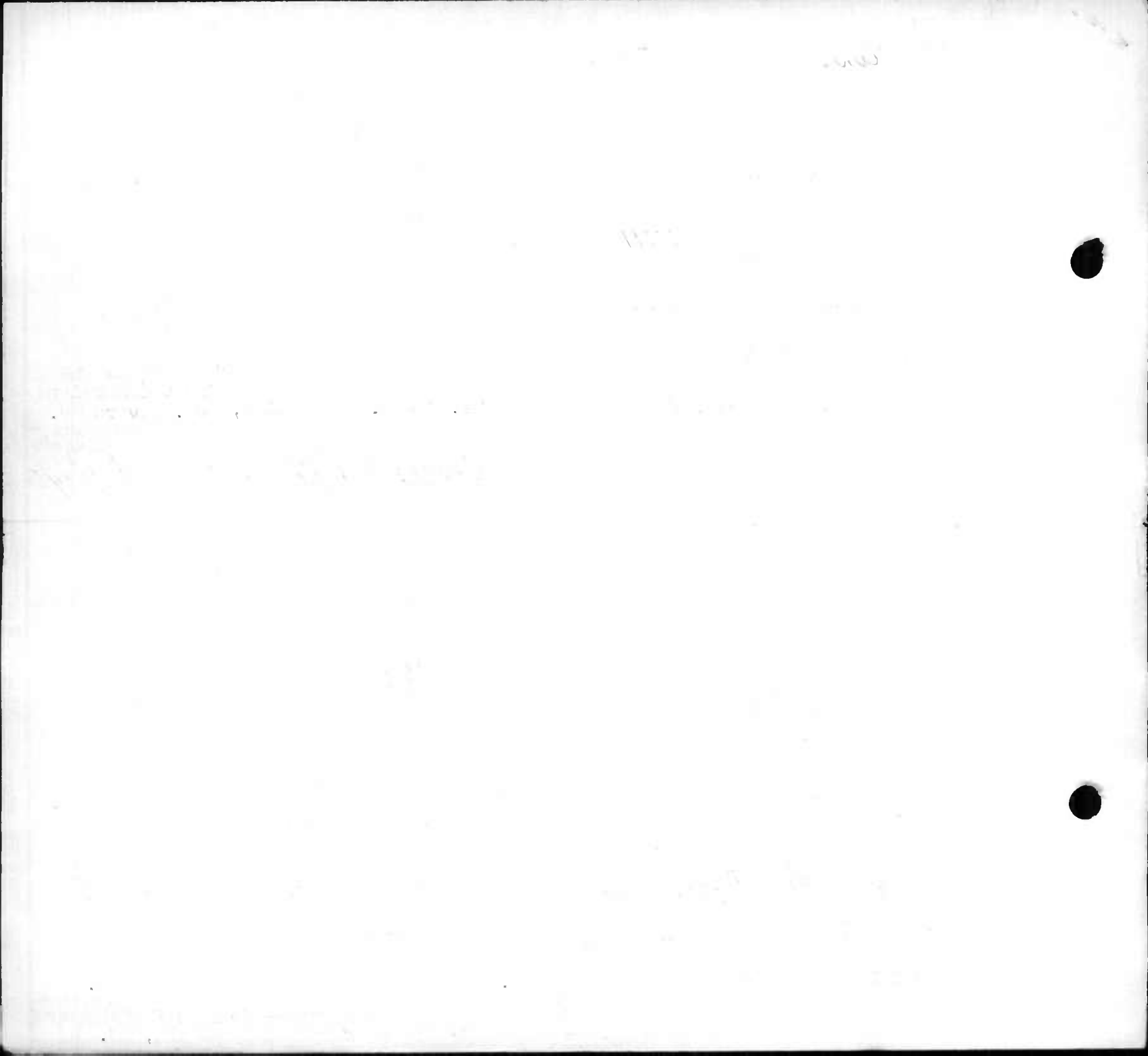


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 08321				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08321			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
M-416 James A. Malafarina				8/29/72 9:05 A.M.				S. B. Co. H.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				5. CITY OR TOWN			
43 S. B. Co. H.				Md. A.A. 5200				Severn			
6. SEX				7. RACE				8. MARITAL STATUS			
M				Caucasian				NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (In years last birthday)				10. DATE OF BIRTH				11. BIRTHPLACE (State or foreign country)			
5				12/17/66				Md.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				Roy C. Malafarina				Eleanora Hamilton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
NO				NONE				Box 908 Maryland Mr. Roy C. Malafarina, Ave. Severn Md.			
18. CAUSE OF DEATH				19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
323X1				Encephalytic				4 Days			
21. ANTECEDENT CAUSES				22. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
24. DATE OF OPERATION				25. CONDITION FOR WHICH OPERATION WAS PERFORMED				26. AUTOPSY? (Yes or No)			
								Yes.			
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
27. TIME OF INJURY (Approx.)				28. INJURY OCCURRED				29. HOW DID INJURY OCCUR?			
27. (Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (H) (this hospital) attended the deceased from 8/25 19 72 to 8/29 19 72				that (H) (we) lost saw the deceased alive on 8/29 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type)			
James A. Kopper M.D.				8/29/72				James A. Kopper M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY			
Burial				9/1/72				GLEN HAVEN MEM. PARK			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
AUG 31 1972				D. J. M. M. M.				Glen Burnie Funeral Home			
26A. ADDRESS				26B. ADDRESS				26C. ADDRESS			
GLEN BURNIE, Md.				GLEN BURNIE, Md.				GLEN BURNIE, Md.			

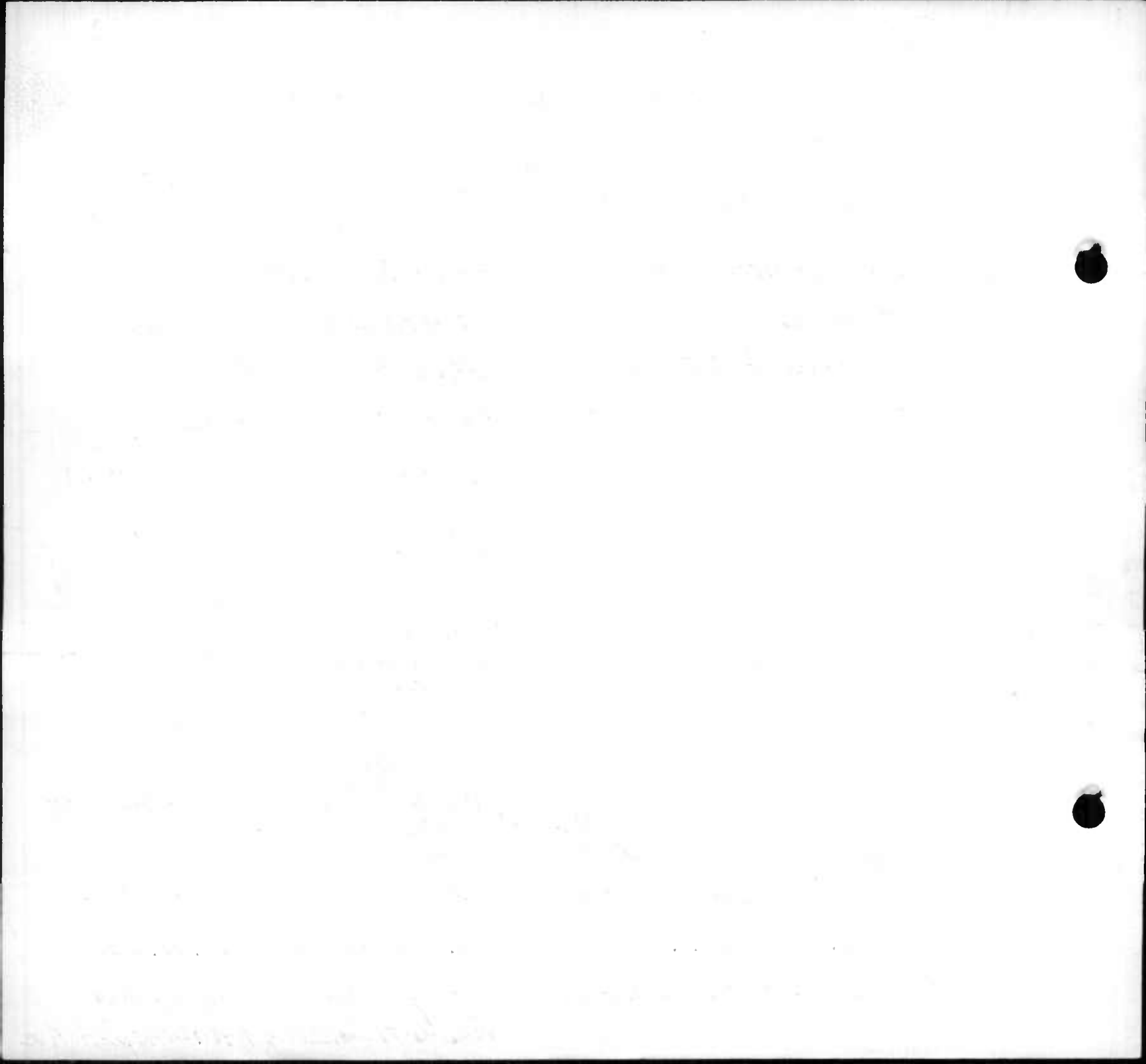




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-315		72 08322		BALTIMORE CITY HEALTH DEPARTMENT		72 08322	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND-DEATH			
GEORGIA H. STEVENS		8-28-72		4:10 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2788			
00 5216 Linden Heights Ave		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER			
5216 Linden Heights Ave		5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country)		12. CITIZEN OF WHAT COUNTRY?	
At Home		BALTIMORE		Md		13. FATHER'S NAME	
George A. Stevens		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
—		—		17. INFORMANT		ADDRESS	
—		—		Wm H. Stevens - Same		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		5 yrs	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Congestive heart failure		10 yrs		(B) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		AS H.D.		(C) DUE TO, OR AS A CONSEQUENCE OF:		—	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Openity		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		—	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
—		—		No		—	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
—		—		—		—	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from		19 67 to 19 67	
—		—		that (I) (we) last saw the deceased alive on		May 5 19 67 and that in (my) (our) opinion death occurred on the date	
—		—		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		—	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Louis H. Schaffer, M.D.		8/29/72		Louis H. Schaffer, M.D.		222 W. Cold Spring Lane, Balt, Md, 21210	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-30-72		Baltimore Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 31 1972		—		—		—	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-236 12 72 08323 BIRTH NO. 12/1/97		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 08323	
1. NAME OF DECEASED (Type or Print) Frank A. Masterson			2. DATE AND HOUR OF DEATH 8/27/72 1:15 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/1/97 9. AGE (in years lost birthday) 74 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager 11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Thomas F. Masterson			14. MOTHER'S MAIDEN NAME Ida Jane Lester		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 012-032302		
17. INFORMANT Frank A. Masterson, Jr.			ADDRESS Same as #4		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of colon metastatic to lung and liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterior ectopic cardiovascular disease with acute myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7, known					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 8/15 19 72 to 8/27 19 72 that (I) (we) last saw the deceased alive on 8/27 19 72 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Karen S. Fountain MD			23B. DATE SIGNED 8/27/72		
23C. PHYSICIAN'S NAME (Type) Karen S. Fountain MD			23D. ADDRESS 910 Belgium Ave., Baltimore, Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE AUG. 31, 1972		24C. NAME OF CEMETERY Gates of Heaven Cem.	
24D. LOCATION Hawthorne		24E. CITY, TOWN, OR COUNTY NEW YORK		24F. STATE NEW YORK	
25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR Audrey M. Wilson		25C. FUNERAL DIRECTOR Wm. Cook Brooks Towson, Inc. Towson, Md.	

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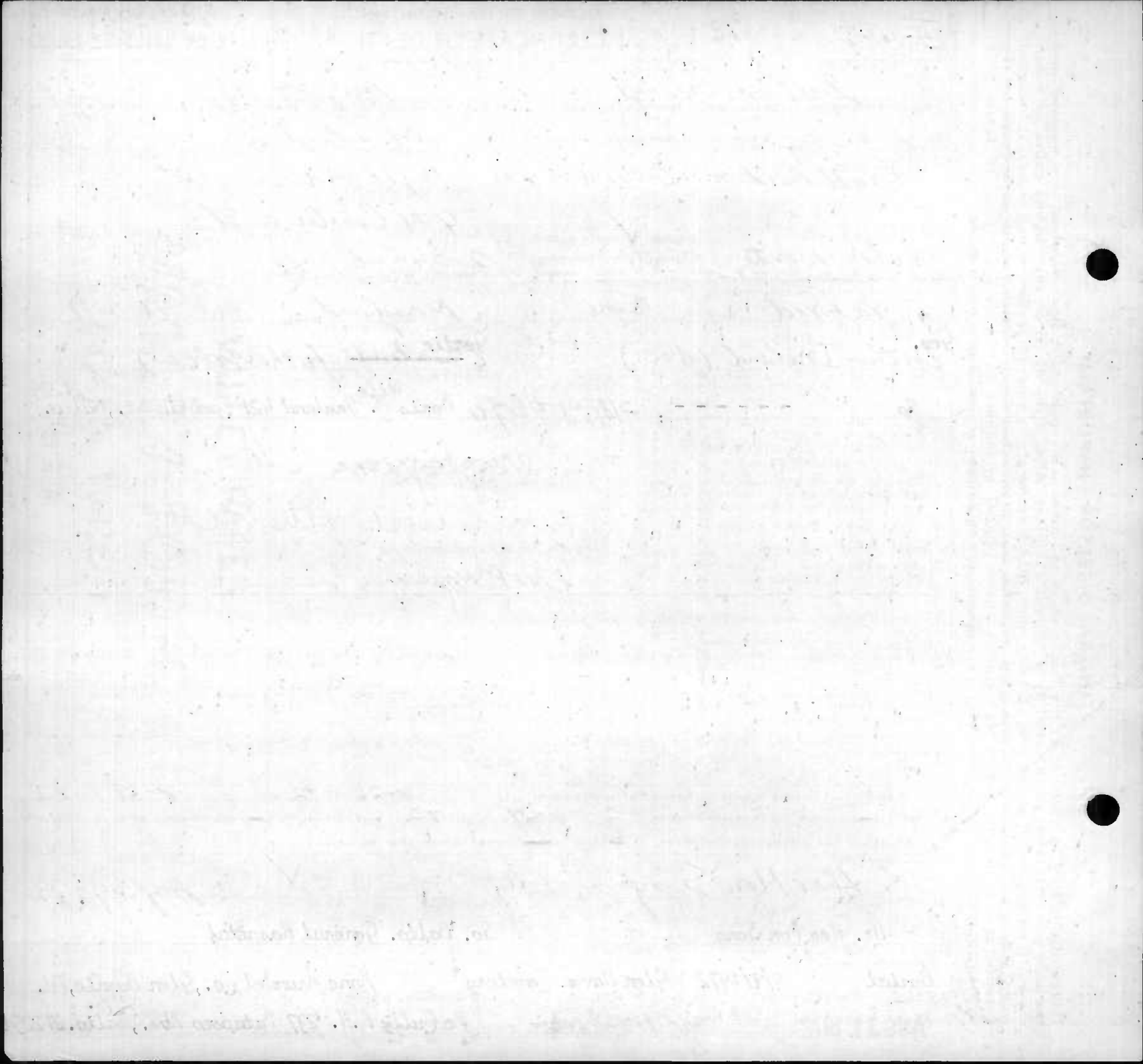
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.


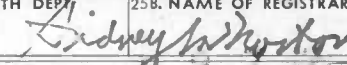
BALTIMORE CITY HEALTH DEPARTMENT				72 08324		72 08324	
T-645 72 08324				CERTIFICATE OF DEATH		STATE OF MARYLAND-DHDC	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Ireland George W.</i>				2. DATE AND HOUR OF DEATH <i>Aug. 29, 1972 12:08 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland.</i> B. COUNTY <i>2534</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>South Baltimore General Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>2-22-108</i>		9. AGE (In years last birthday) <i>66</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Patricia Ireland (dec.)</i>				14. MOTHER'S MAIDEN NAME <i>Gertrude Fisher (dec.)</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>288-01-0889</i>		17. INFORMANT <i>Wife</i>	
18. <i>43691</i>				19. CAUSE OF DEATH		ADDRESS <i>21225</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction CVA</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Generalized atherosclerosis</i>			
				(C) <i>Emphysema</i>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-26 1972</i> to <i>8-29 1972</i> , that (I) (we) last saw the deceased alive on <i>8-29 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Hee Man Song</i>				23B. DATE SIGNED <i>Aug. 29, '72</i>			
23C. PHYSICIAN'S NAME (Type) <i>Dr. Hee Man Song</i>				23D. ADDRESS <i>So. Balto. General Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/1/1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Anne Arundel Co., Glen Burnie, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 31 1972</i>		25B. NAME OF REGISTRAR <i>Sidney H. Horken</i>		25C. FUNERAL DIRECTOR <i>Mc Gully F.H.</i>		ADDRESS <i>237 Patapsco Ave., Balto. 21225</i>	

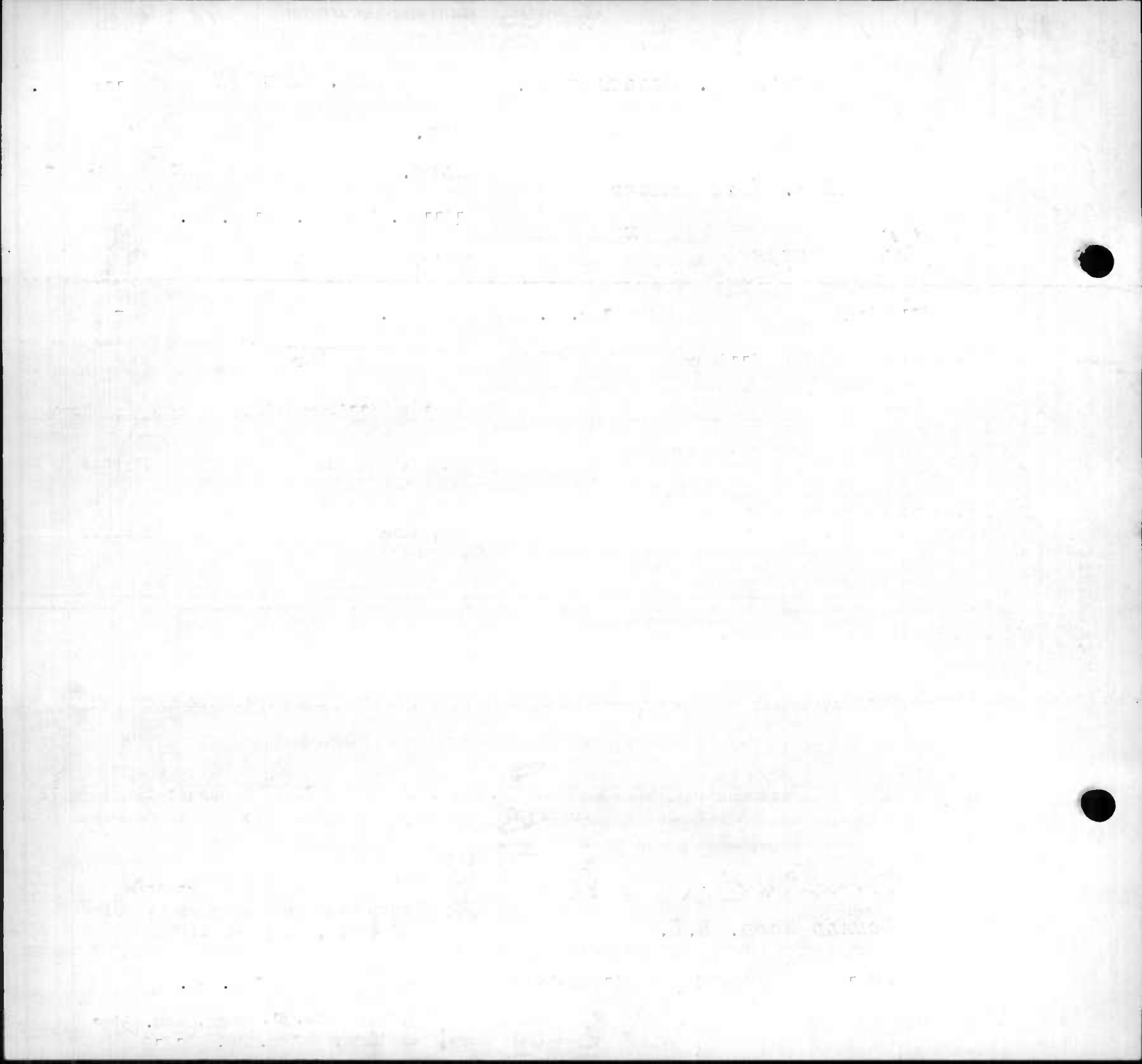




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08325	REG. NO. 72 08325
<b>1. NAME OF DECEASED</b> (Type or Print) <b>NORMAN F. FILLIAUX SR.</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>AUG. 22ND 72</b>		<b>11:45 P.M.</b>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1311 E. 36TH STREET</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>903</b>  C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  E. STREET AND NUMBER <b>1311 E. 36th St. Balto. Md.</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3/23/08</b>	<b>9. AGE</b> (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Millwright</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Western Elec. Co.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MD.</b>	
<b>13. FATHER'S NAME</b> <b>Frank Filliaux</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>May Nunemaker</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Thelma Filliaux (wife)</b> ADDRESS <b>same as above</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>168.1 I</b> <b>Carcinomatosis</b>  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>CA, lung</b>			<b>CAUSE OF DEATH</b>  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)		
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>8 years</b>  <b>8 years</b>		
<b>19A. DATE OF OPERATION</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (the hospital) attended the deceased from August XX 19 19 72 to August 22 19 72, that (I) (we) lost saw the deceased alive on August 19 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (we) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> 				<b>23B. DATE SIGNED</b> <b>8-22-72</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>DONALD WOOD. M.D.</b>				<b>23D. ADDRESS</b> <b>York Road and Greenmeadow Drive Timonium, Maryland 21093</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>8/25/72</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Woodlawn Cemetery</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Balto. Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>AUG 31 1972</b>			
<b>25B. NAME OF REGISTRAR</b> 		<b>25C. FUNERAL DIRECTOR</b> <b>Schimunek Funeral Homes, Inc. 3331 Brehms</b>			

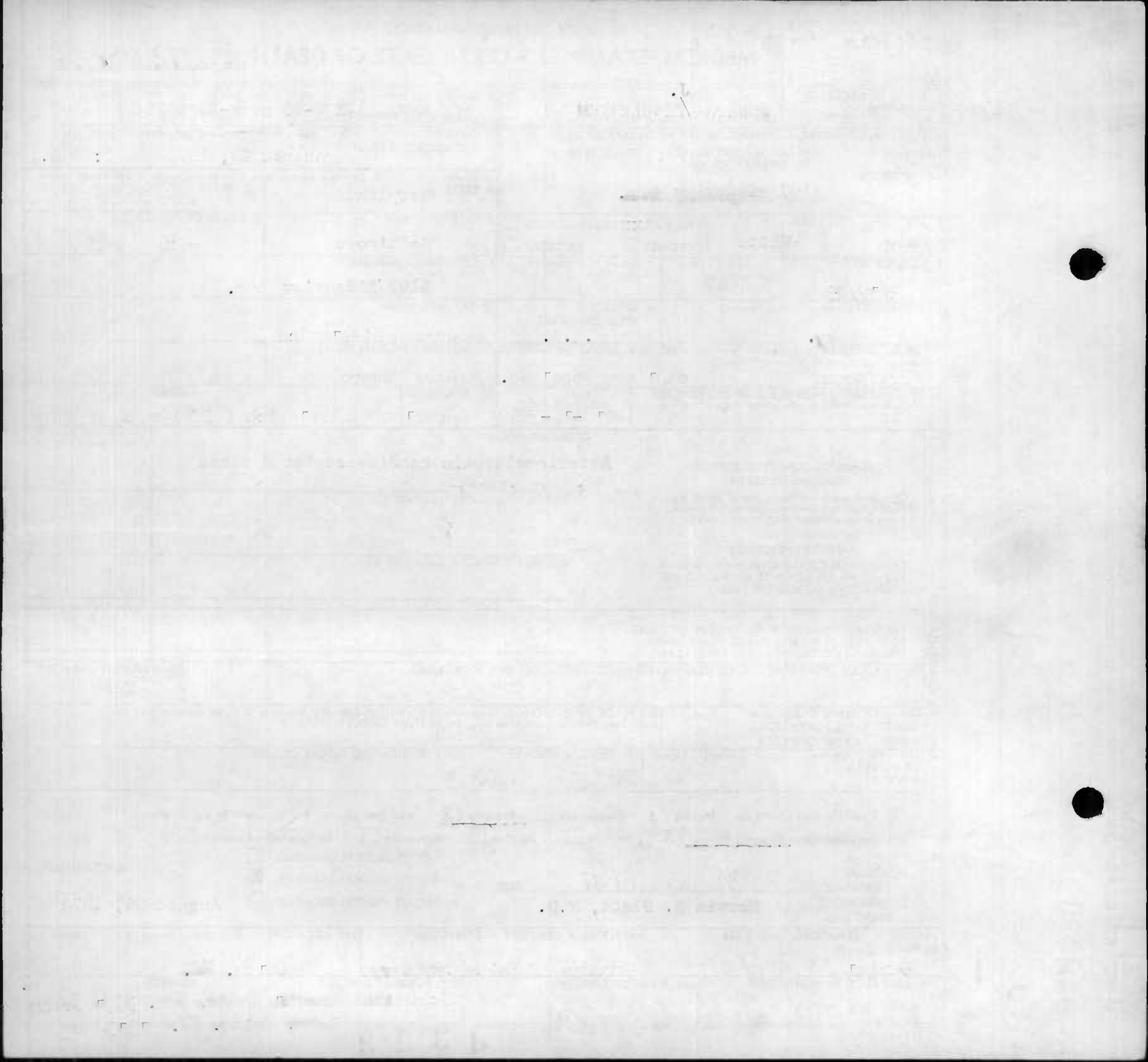


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08226

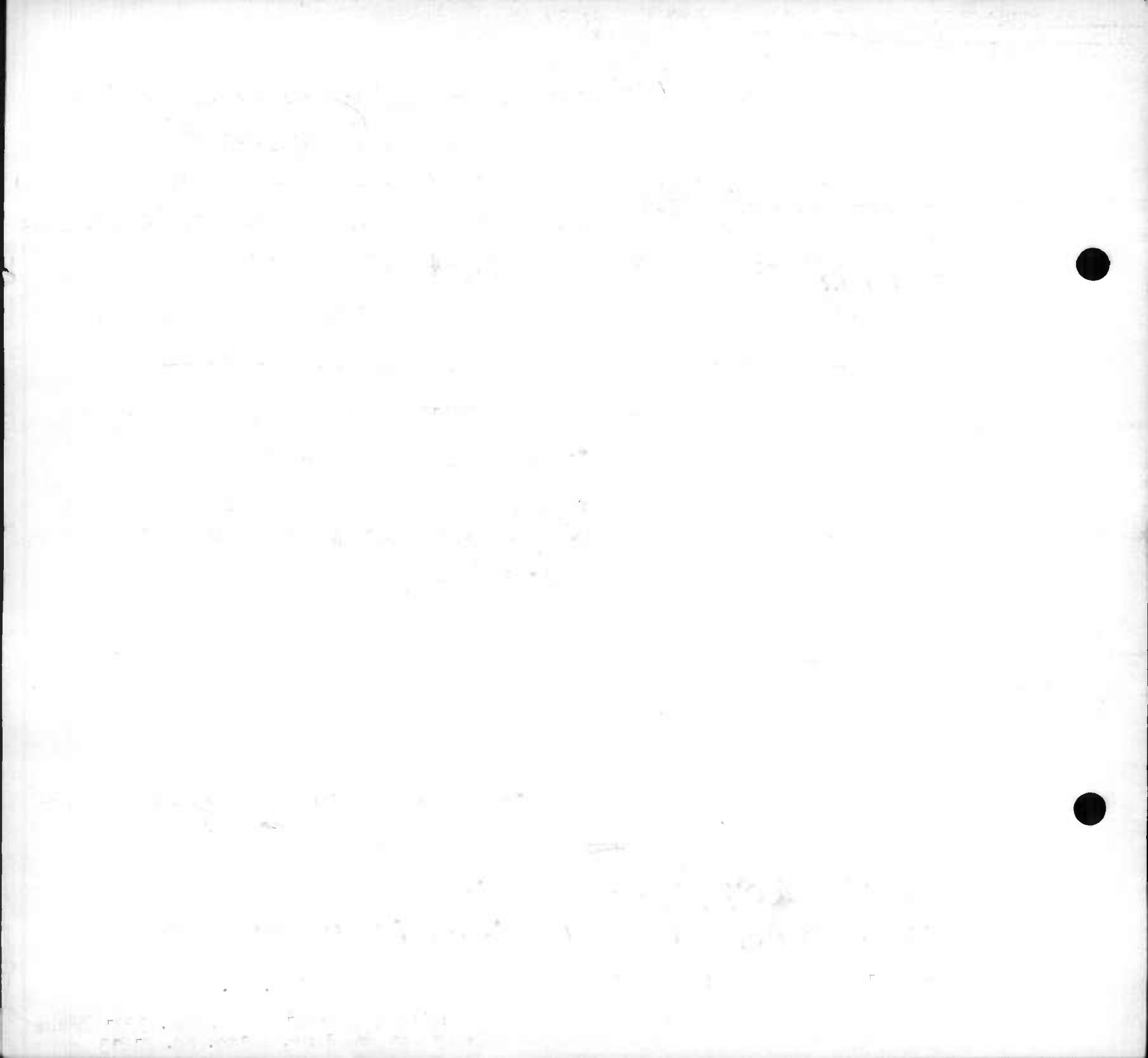
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH KISELEWICH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 8-23 or 8-24 72		Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>6107 Ridgeview Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 24, 1972</b>		Hour <b>7:20 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>2/19/23</b>		10. AGE (in years lost birthday) <b>49</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Kiselewich</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Nasuro</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW II</b>		17. SOCIAL SECURITY NO. <b>218-78-9949</b>	
18. INFORMANT <b>Charlotte Kiselewich (wife)</b>		19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		20. ADDRESS <b>same as above</b>	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:</b>		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		25. DATE OF OPERATION <b>8/28/72</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
30. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
33. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
34. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		35. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		36. DATE SIGNED <b>August 24, 1972</b>	
37. 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		38. 24B. DATE <b>8/28/72</b>		39. 24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>	
40. 24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		41. 25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		42. 25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
43. 25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>		44. 25D. ADDRESS		45. 25E. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-260 72 08327		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08327
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND DEPT
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
ETTA Lena Decker		Aug 24 1972 1 72 <sup>00</sup> PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
Midtown Home 90 808 St Paul St. Balt Maryland 21202		4516 Parkside Dr Bc 2642		
5. SEX 6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH
Female White				3/24/85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)
Housewife		at home		87
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Virginia		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
George Taylor		Lillian L. Voris		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
UNKNOWN		212-05-887-8		Lillian Voris (dghtr) same as above
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Cardio-Respiratory Failure		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arteriosclerotic CHD		
		(B) Gen + Cerebral Arteriosclerosis		
		DUE TO, OR AS A CONSEQUENCE OF:		
		(C) Senility		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from Feb 11 1971 to Aug 24 1972 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Lillian L. Voris				
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
William D Appleford MD		6615 Reisterstown Rd		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		8/28/72		Oak Lawn Cemetery
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		
Balt. Md.				
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
AUG 31 1972		Lillian L. Voris		Schimmek Funeral Homes, Inc. 3331 Brehms
VS 150-REV. 1-7-68		Tow, Balt. Md. 21213		

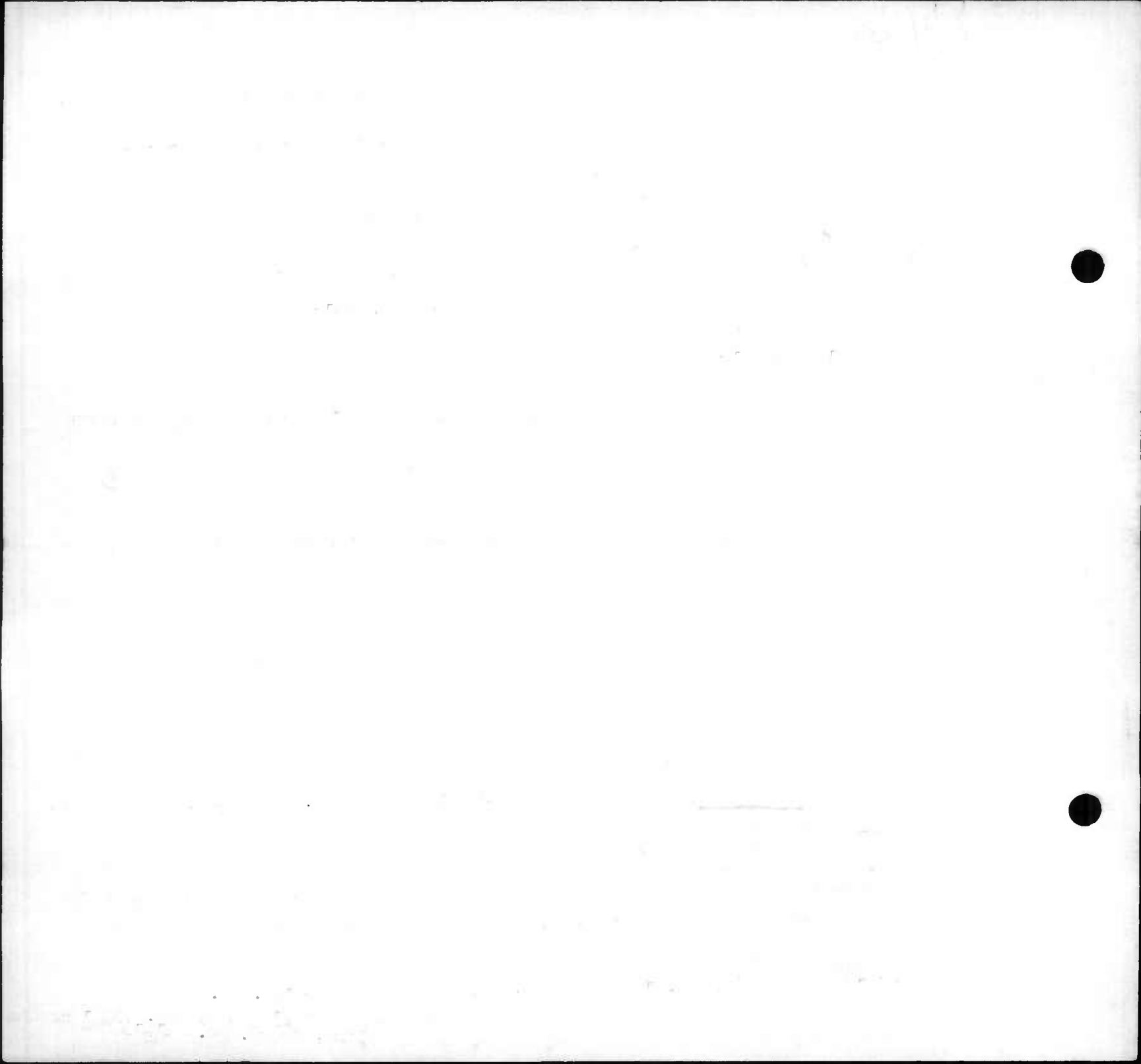


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 08228</u> STATE OF MARYLAND- <del>DEPT</del>	
BIRTH NO. <u>M-624</u> <u>72 08228</u>					
1. NAME OF DECEASED (Type or Print) <u>Marsalek, George</u>		2. DATE AND HOUR OF DEATH <u>8/24/72</u> <u>1</u> <u>5</u> <u>P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hospital</u> <u>45</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2404 Lake Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/18</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (State or foreign country) <u>Cal. Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Vadslav Marsalek</u>			
14. MOTHER'S MAIDEN NAME <u>Bessie Petrilik</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>212097271</u>		17. INFORMANT ADDRESS <u>Marie Marsalek (wife) same as above</u>			
18. <u>4-3391-25019</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral Artery Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes</u>					
19A. DATE OF OPERATION <u>8/24</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>Good Samaritan Hosp.</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> 19 <u>72</u> to <u>8/24</u> 19 <u>72</u> and that (I) (we) lost saw the deceased alive on <u>8/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mahmud A. Thamer, M.D.</u>		23B. DATE SIGNED <u>8/24/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Mahmud A. Thamer, M.D.</u>	
23D. ADDRESS <u>Good Samaritan Hosp.</u>		23E. ADDRESS <u>Schimunek Funeral Homes, Inc.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8/28/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR <u>Adrian Johnson</u>		25C. FUNERAL DIRECTOR <u>4324 Ave. Balto. Md. 21213</u>	

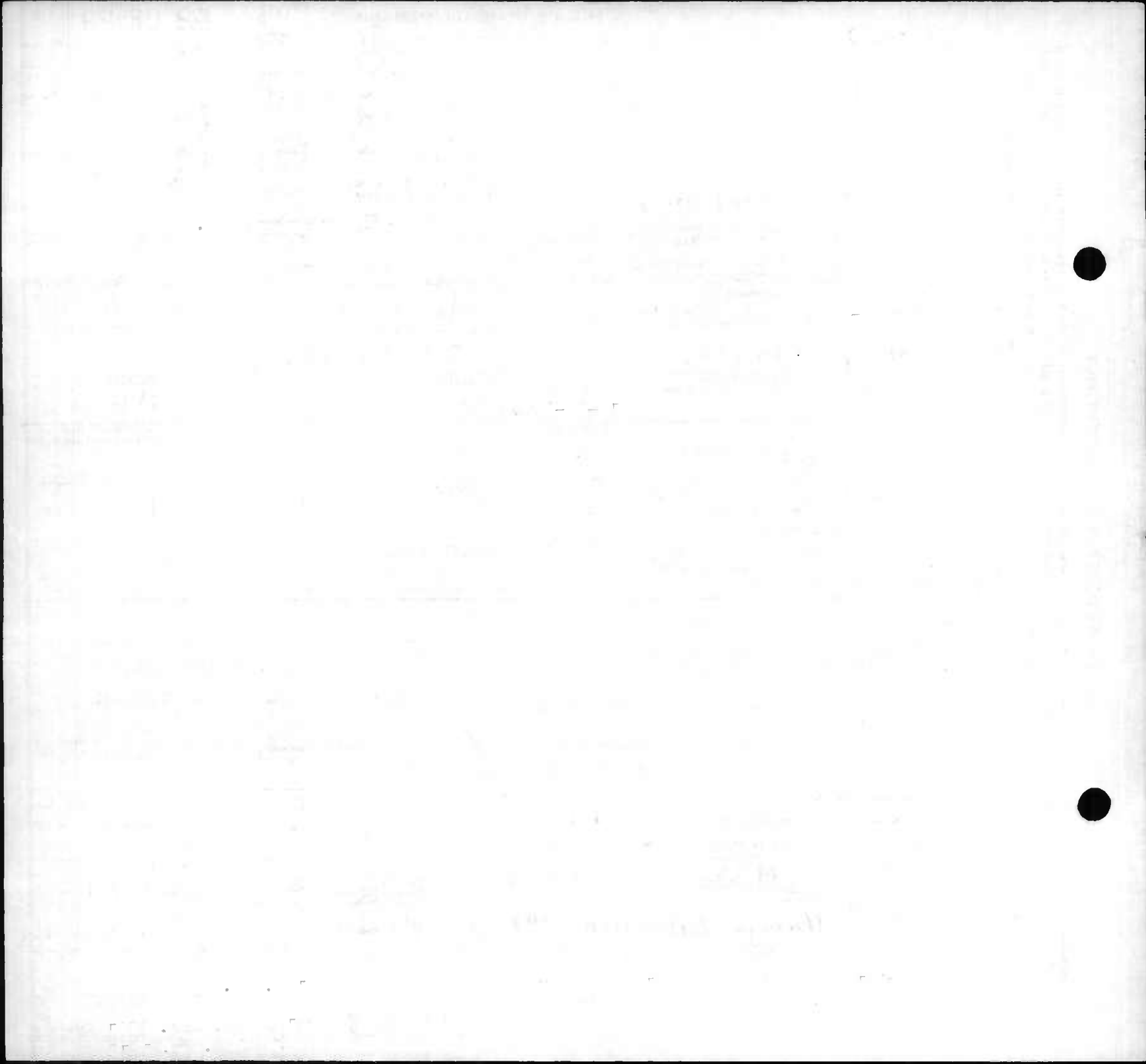




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

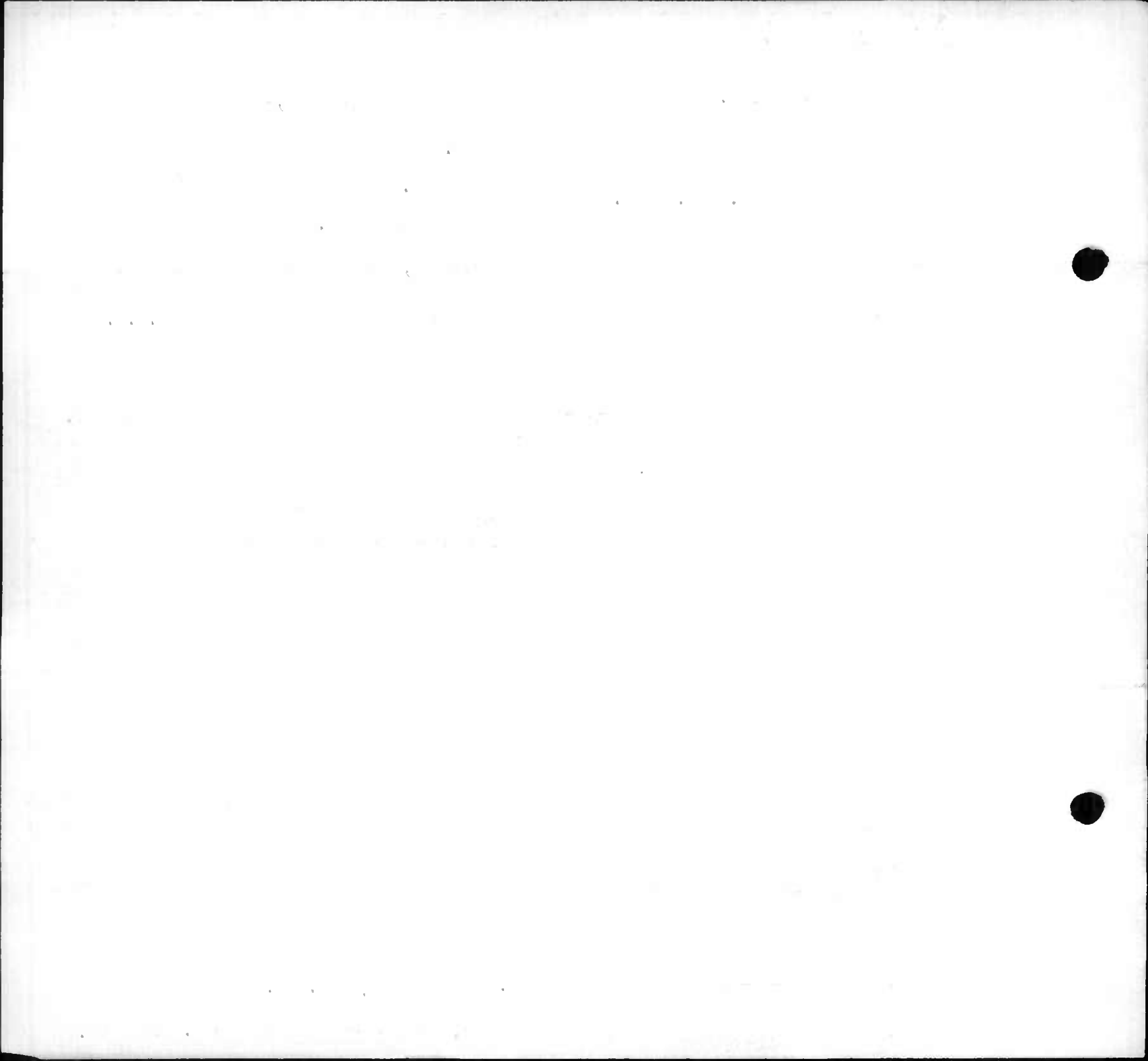
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH										
BIRTH NO. <span style="float: right;">72 08-29</span>					REG. NO. <span style="float: left;">72 08-29</span>					
1. NAME OF DECEASED (Type or Print) <b>MOOSE GLADYS May</b>					2. DATE AND HOUR OF DEATH <b>8/27/72 2 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>U.S.A.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4825 Frankford Ave.</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-12</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waitress-Retired.</b>			
10B. KIND OF BUSINESS OR INDUSTRY <b>Read's Drug</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>CARRON, Charles</b>					14. MOTHER'S MAIDEN NAME <b>SMITH, Mary.</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>			16. SOCIAL SECURITY NO. <b>216-38-3806</b>		17. INFORMANT <b>Chart</b>			ADDRESS <b>U.M.H.</b>		
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Old CVA, Urinary tract infection.</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (N) (this hospital) attended the deceased from <b>8/26</b> 19 <b>72</b> to <b>8/27</b> 19 <b>72</b> that (N) (we) last saw the deceased alive on <b>8/27</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>M. Shocair M.D.</b>					23B. DATE SIGNED <b>8/27/72.</b>			23C. PHYSICIAN'S NAME (Type) <b>Mawya SHOCAIR MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>8/30/72</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>			25B. NAME OF REGISTRAR <b>Adrian B. Weston</b>			25C. FUNERAL DIRECTOR <b>Selfmunk Funeral Homes, Inc.</b>			ADDRESS <b>3331 Brehms Lane, Balto. Md. 21213</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-142		72 08330		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08330	
BIRTH NO.				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <i>Caroline M. De Falco</i>				2. DATE AND HOUR OF DEATH <i>August 27, 1972</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 South Balto. Gen. Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission). A. STATE <i>Md.</i> B. COUNTY <i>2402</i>			
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 24, 1906</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry Yingling</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-30-9466A</i>		17. INFORMANT ADDRESS <i>Lois Leiching (Daughter) 1604 Jackson St.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Coronary Occlusion</i> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Hypertensive Cardiovascular Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>instantaneous</i> <i>years</i>							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <i>8-27-72</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>8-21</i> 19 <i>72</i> to <i>8-27</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>8-27</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Roberto V. Gomez MD</i>				23B. DATE SIGNED <i>8-29-72</i>		23C. PHYSICIAN'S NAME (Type) <i>Roberto V. Gomez MD</i>	
23D. ADDRESS <i>McGully Funeral Home 130 E. Font Ave. 21230</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8-30-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cent.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 31 1972</i>		25B. NAME OF REGISTRAR <i>Anthony Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>McGully Funeral Home 130 E. Font Ave. 21230</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08331	
N-550 72 08331				REG. NO. 72 08331	
BIRTH NO.				STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) Benjamin P. Noonan			2. DATE AND HOUR OF DEATH 8-26-72 5:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 103 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2536 Foster Avenue 2536 FOSTER AVE.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-25	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10B. KIND OF BUSINESS OR INDUSTRY Noonan Heating & Plumbing MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Noonan WILLIAM H.			14. MOTHER'S MAIDEN NAME Rose Lawicki		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 219-12-6983		17. INFORMANT Mother: Mrs. Rose Lawicki 7100 Martell Ave. Dundalk, Md. 21222	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cachexia. Bleeding esophageal varices more than years  (B) DUE TO, OR AS A CONSEQUENCE OF: Portal hypertension more than years  (C) Metastatic carcinoma of abdominal lymph nodes more than years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).					
19A. DATE OF OPERATION 8/22/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding esophageal varices		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-3 19 72 to 8-26 19 72, that (I) (we) last saw the deceased alive on 8-26 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Susumu Kinjo MD				23B. DATE SIGNED 8/26/72	
23C. PHYSICIAN'S NAME (Type) Susumu Kinjo MD		23D. ADDRESS 3001 South Harrier St. Balg South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-30-72		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972			
25B. NAME OF REGISTRAR Audrey Johnson		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md.			





# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08332

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK A. HARRON Harrod		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour August 26, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (DOA) 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour August 26, 1972 12:40 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Prince Georges	
9. DATE OF BIRTH Nov. 11, 1932		10. AGE (in years last birthday) 39	
11. BIRTHPLACE (State or foreign country) Blackford, Fy.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N.S.A.		14B. KIND OF BUSINESS OR INDUSTRY NSA	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3/11/53 to 3/7/55		17. SOCIAL SECURITY NO. 405-34-1959	
18. INFORMANT ADDRESS Laurel, Md.		19. MOTHER'S MAIDEN NAME Verne Crowell	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Expressway	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 8-26-72 12:01 A.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Driver in auto-fixed object collision		21. AUTOPSY? (Yes or No) Yes	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 815.0 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Expressway		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3572 Balt.-Wash. Expressway, S. of Annapolis Road	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 8-26-72 12:01 A.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto-fixed object collision	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 26, 1972 ACTUAL SIGNATURE Peter Lipkovic, M.D.					

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/28/72		24C. NAME of CEMETERY or CREMATORY Meadowridge Mem. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Howard Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR Sidney H. Hoston		25C. FUNERAL DIRECTOR ADDRESS Laurel Funeral Home Inc. 550 Washington Bl. of Howard M. Fleck Laurel, Md. 20810			

200

100



*Handwritten signature or initials*

# FUNERAL DIRECTOR: IMPORTANT

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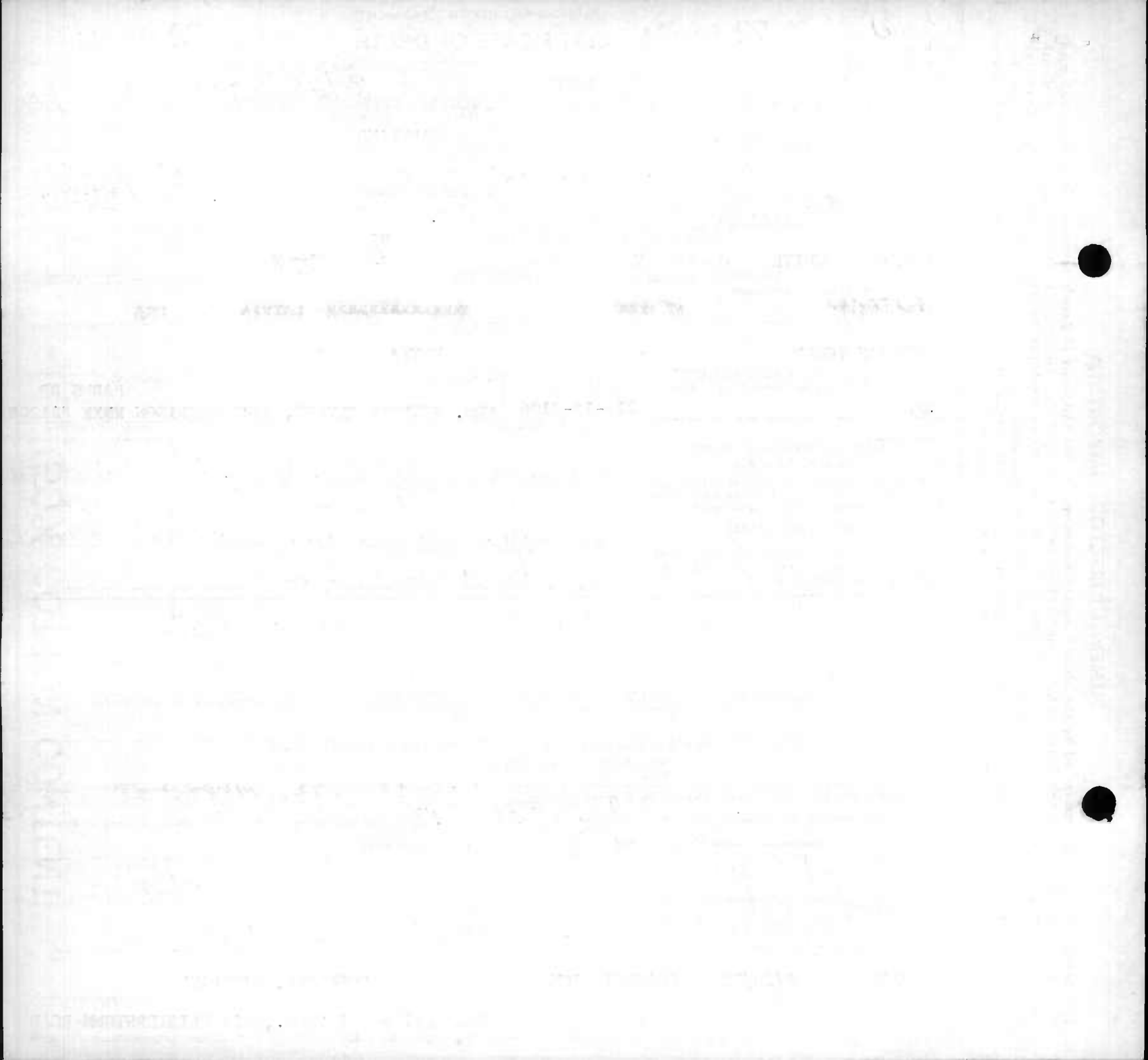
BALTIMORE CITY HEALTH DEPARTMENT		72 08333		72 08333	
D-250		72 08333		72 08333	
BIRTH NO.		72 08333		72 08333	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		STATE OF MARYLAND - D.D.M.	
DIXON, ALBERT (NMI)		8-23-72		5:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. C.		V 48	
Veterans Administration Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218		C. CITY OR TOWN WASHINGTON		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 4/26/10		9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK	
11. BIRTHPLACE (State or foreign country) SNOW HILL, N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME THOMAS E. DIXON	
14. MOTHER'S MAIDEN NAME MATTIE TURNAGE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 11/2/43 to 11/14/45		16. SOCIAL SECURITY NO. 579 03 65 11	
17. INFORMATION Medical Records		18. CAUSE OF DEATH		19. ADDRESS VA Hospital, Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF METASTATIC CARCINOMA OF RIGHT LUNG		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). * Bronchoscopy (R) Anterian Thoracotomy determined accurate diagnosis and curability of lesion	
19A. DATE OF OPERATION 7/21/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED see above		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from July 7 19 72 to August 23 19 72, that (I) (we) lost saw the deceased alive on August 23 19 72 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE William Shaw, M. D.	
23B. DATE SIGNED 8/23/72		23C. PHYSICIAN'S NAME (Type) WILLIAM SHAW, M. D.		23D. ADDRESS VA Hospital, Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-31-72		24C. NAME OF CEMETERY or CREMATORY HARMONY MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) PRINCE GEORGE, MARYLAND		25A. DATE RECEIVED BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR John T. Rhines Company Funeral Home 3015 12th Street, N. E., Washington, D. C.		25D. ADDRESS John T. Rhines Company Funeral Home 3015 12th Street, N. E., Washington, D. C.		25E. ADDRESS John T. Rhines Company Funeral Home 3015 12th Street, N. E., Washington, D. C.	

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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08334</u>
<p><b>1. NAME OF DECEASED</b> (Type or Print) <u>Paul, Sarah</u> TONEY</p>		<p><b>2. DATE AND HOUR OF DEATH</b> <u>8/28/1972</u> <u>7:30</u> P.M.</p>		
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2740</u></p>		
<p><b>5. SEX</b> <u>FEMALE</u></p>		<p><b>6. RACE</b> <u>WHITE</u></p>		
<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <u>95</u> <u>7-12-XXX</u> <b>9. AGE</b> (In years last birthday) <u>77XX</u></p>		
<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <u>XXXXXXXXXX LATVIA</u></p>		
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u></p>		<p><b>13. FATHER'S NAME</b> <u>MATHIAS TONEY</u></p>		
<p><b>14. MOTHER'S MAIDEN NAME</b> <u>YETTA ?</u></p>		<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		
<p><b>16. SOCIAL SECURITY NO.</b> <u>213-18-2196</u></p>		<p><b>17. INFORMANT</b> <u>MRS. ANNETTE MEYERS, 3423 GARRISON FARMS RD #21208</u></p>		
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Central Circulatory &amp; Respiratory failure</u></p>		<p><b>19. CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cancer of Colon &amp; Metastasis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>to distant organs</u> (C) <u>to distant organs</u></p>		
<p><b>20. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Dehydration</u> <u>Metastasis</u></p>		<p><b>21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 days</u> <u>about 8 months</u></p>		
<p><b>22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>		<p><b>23. DATE OF OPERATION</b> <u>1972</u></p>		
<p><b>24. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>25. AUTOPSY?</b> (Yes or No) <u>No</u></p>		
<p><b>26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		<p><b>27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		
<p><b>28. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>29. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		
<p><b>30. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>1972</u></p>		<p><b>31. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		
<p><b>32. HOW DID INJURY OCCUR?</b></p>		<p><b>33. I certify that (I) (this hospital) attended the deceased from</b> <u>May 15</u> 19<u>72</u> to <u>August 28</u> 19<u>72</u> that (I) (we) last saw the deceased alive on <u>August 28</u> 19<u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>		
<p><b>34. SIGNATURE</b> <u>H. Yun, M.D.</u></p>		<p><b>35. DATE SIGNED</b> <u>8/28/72</u></p>		
<p><b>36. PHYSICIAN'S NAME</b> (Type) <u>Hyo-Yun Yun, M.D.</u></p>		<p><b>37. ADDRESS</b> <u>Maryland General Hospital</u></p>		
<p><b>38. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u></p>		<p><b>39. DATE</b> <u>8/29/72</u></p>		
<p><b>40. NAME OF CEMETERY or CREMATORY</b> <u>SHAAREI ZION</u></p>		<p><b>41. LOCATION</b> (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u></p>		
<p><b>42. DATE RECEIVED BY HEALTH DEPT.</b> <u>AUG 31 1972</u></p>		<p><b>43. NAME OF REGISTRAR</b> <u>SOI LEVINSON &amp; BROS.</u></p>		
<p><b>44. FUNERAL DIRECTOR</b> <u>SOI LEVINSON &amp; BROS.</u></p>		<p><b>45. ADDRESS</b> <u>6010 REISTERSTOWN ROAD</u></p>		

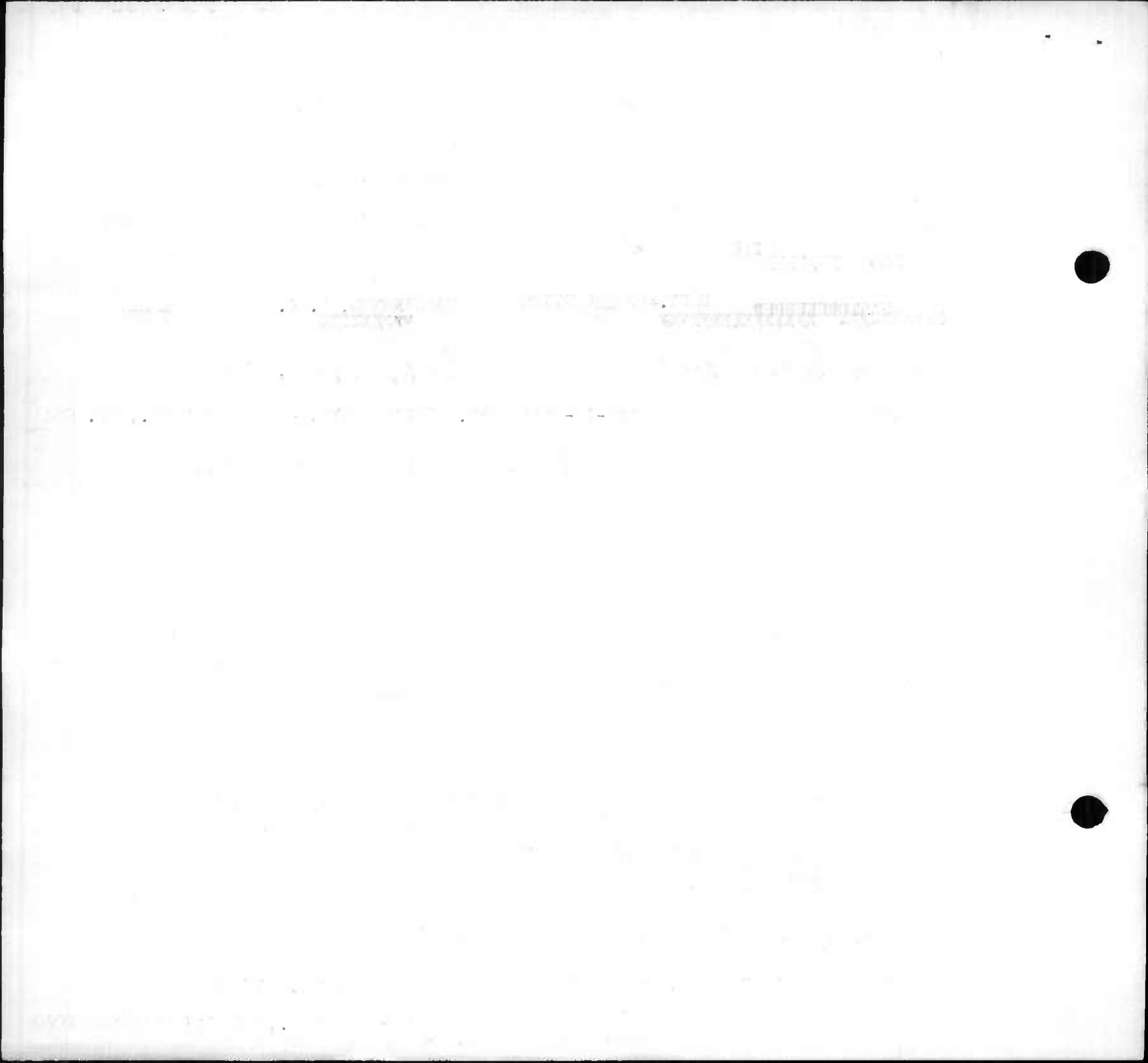




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B-120		72 08335		BALTIMORE CITY HEALTH DEPARTMENT		72 08335	
BIRTH NO.		CERTIFICATE OF DEATH				REC. NO.	
1. NAME OF DECEASED (Type or Print) <b>HARRY A. BOBYS</b>		2. DATE AND HOUR OF DEATH <b>27 Aug. 1972 7<sup>10</sup> P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital Lombard + Greene Sts. Balto. Md.</b>		A. STATE <b>Maryland</b>				B. COUNTY <b>Baltimore City</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>6800 Liberty Rd.</b>				<b>Apt 504</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-24-09</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DEPT. OF EDUCATION</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Bobys (dec)</b>		14. MOTHER'S MAIDEN NAME <b>Schreiber, SARAH</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>212-12-9681</b>		17. INFORMANT <b>MRS. MIRIAM BOBYS, 6800 LIBERTY RD., APT. 504</b>					
18. CAUSE OF DEATH <b>189.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Renal Cell CA metastasis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>2 years</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>					
19. DATE OF OPERATION <b>18-1-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>HE</b> (this hospital) attended the deceased from <b>7-22</b> 19 <b>72</b> to <b>8-27</b> 19 <b>72</b> and that (I) <b>WAS</b> last saw the deceased alive on <b>8-27</b> 19 <b>72</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>WAS</b> (did) (did not) view the body after death.							
23A. SIGNATURE <b>STEPHEN D. ROSENBAUM, MD</b>				23B. DATE SIGNED <b>27 Aug.</b>		23C. PHYSICIAN'S NAME (Type) <b>STEPHEN D. ROSENBAUM, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/29/72</b>		24C. NAME of CEMETERY or CREMATORY <b>GEORGE WASHINGTON</b>		24D. LOCATION (City, town, or county) (State) <b>ADELPHI, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Adrienne Weston</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

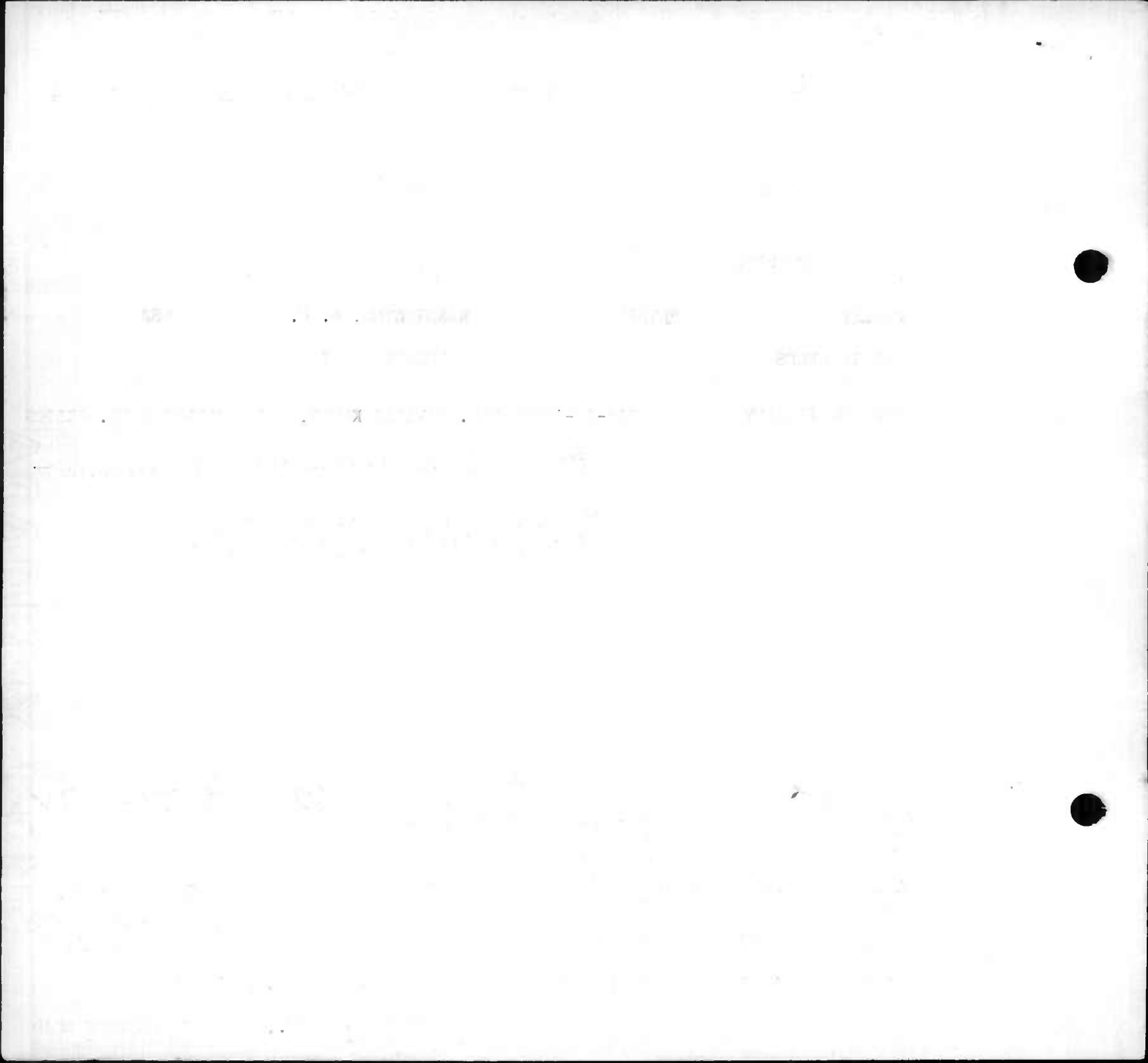




# FUNERAL DIRECTOR: IMPORTANT

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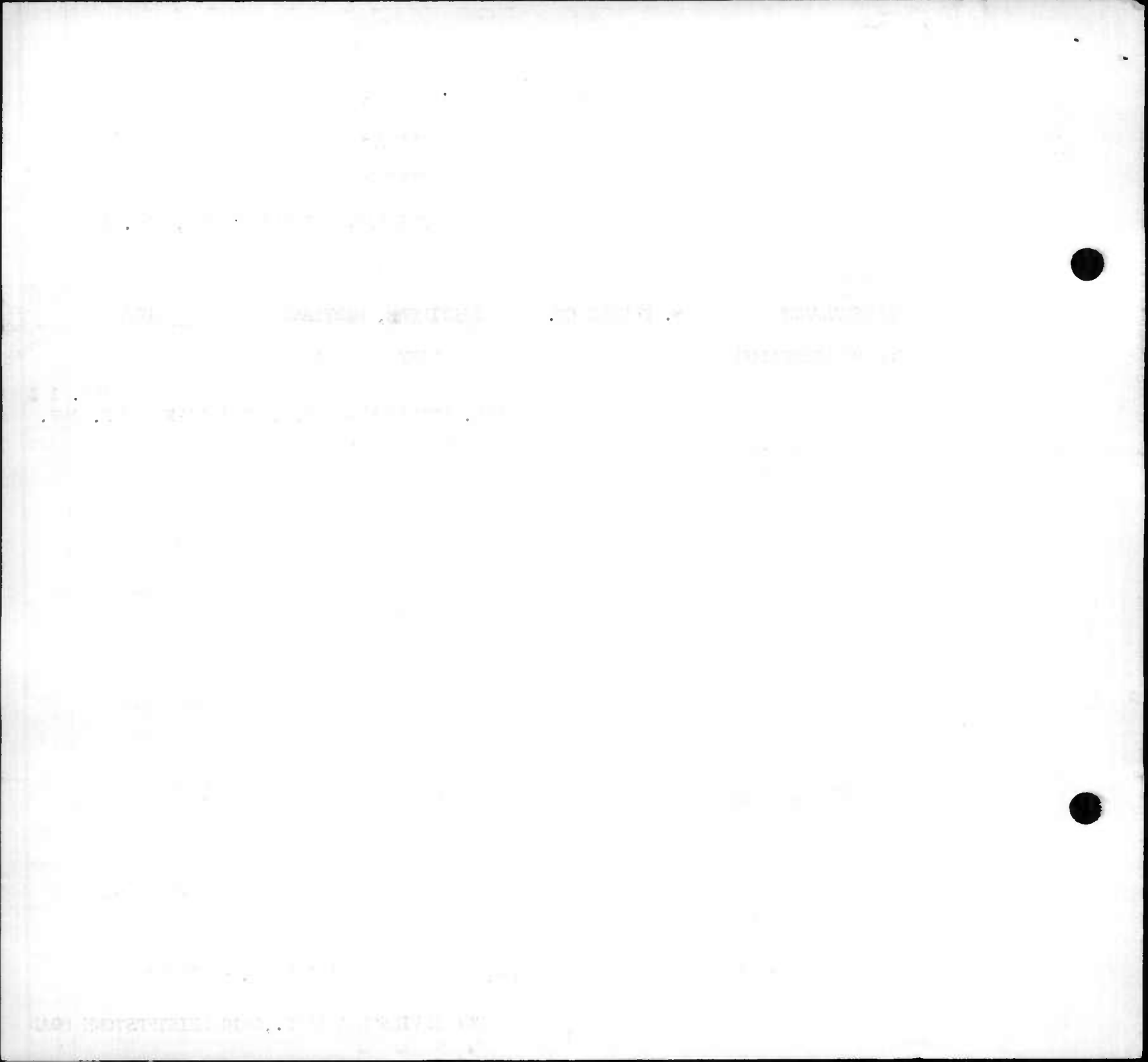
BIRTH NO. <b>K-612</b>		72 08336		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08336</b>	
1. NAME OF DECEASED (Type or Print) <b>KREPS, JOSEPH</b>				2. DATE AND HOUR OF DEATH <b>8-27-72 345 A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6614 BAYTHORNE RD 21209</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/2/11</b>	9. AGE (In years last birthday) <b>61</b>	10. Under 1 Tr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCEER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MORRIS KREPS</b>				14. MOTHER'S MAIDEN NAME <b>MOLLIE ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II ARMY</b>		16. SOCIAL SECURITY NO. <b>216-10-1905</b>		17. INFORMANT ADDRESS <b>MRS. MATILDA KREPS, 6614 BAYTHORNE RD. #21209</b>			
18. <b>412.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ARTERIOSCLEROTIC C.V.D.</b> <b>ACUTE M.I. 6URS. A.S.O.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>			
19A. DATE OF OPERATION <b>6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>19 60</b> to <b>8-27-19 72</b> and that (1) (we) lost saw the deceased alive on <b>Approx. 2 mos. prior</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph Deckerbaum</b>				23B. DATE SIGNED <b>8-27-72</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSEPH DECKERBAUM, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/29/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>WORKMEN CIRCLE</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE OF DEATH <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Admiral [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SQL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08237	
BIRTH NO. 4536 72 08237				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HENDERSON HERBERT H.</b>		2. DATE AND HOUR OF DEATH <b>8/27/72 1 510 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4 Sinai Hospital of Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2740</b>			
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>6503 PARK HEIGHTS AVENUE, APT. 1L</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/17</b>	9. AGE (In years last birthday) <b>55</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMANAGER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>M. KOVENS CO.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>JOSEPH HENDERSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. SYLVIA HENDERSON, 6503 PARK HIGHTS, AVE.</b>	
				ADDRESS <b>APT. 1 L</b>	
18. <b>200.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>ventricular fibrillation - renal failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>septic shock due to leucopenia and Pseudomonas infection</b>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Rx for Retinulum cell sarcoma - 2</b>			
		(C) <b>abscess of abdominal wall</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>1 8/24/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>necrosis of side of abdominal wall</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/24</b> 19 <b>72</b> to <b>8/27</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>8/27</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. LEVEQUE</b>		23B. DATE SIGNED <b>8/27/72</b>		23C. PHYSICIAN'S NAME (Type) <b>H. LEVEQUE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/29/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>OHEB SHALOM MEMORIAL PARK</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sol Levinson</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	
				ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08038	
G-653				72 08038	
BIRTH NO.				STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GRANDBERG, IRVING B.		08-24-72 1:40 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
The Union Memorial Hospital			Maryland 1201		
5. SEX			6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
MALE			WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
XXXXXXXXXX ATTORNEY		SELF EMPLOYED		06-26-98 74 XX	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)
Grandberg, Irving Henry			Annie Schapiro		74 XX
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?
XXXXXXXXXX			XXXXXXXXXX		American
17. INFORMANT			ADDRESS		
XXXXXXXXXX			LEVINE CHAPEL INC., 470 HARVARD ST. BROOKLINE, MASS., XXXXX 02146		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cardiorespiratory arrest 20 min.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Acute Myocardial Infarction 3 days.		
II			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work			
22. I certify that (I) (this hospital) attended the deceased from 08-22-1972 to 08-24-1972, that (I) (we) last saw the deceased alive on 08-24-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dante Manysi M.D.				08-24-72	
23C. NAME (Type)				23D. ADDRESS	
DANTE MANYSI M.D.				The Union Memorial Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
REMOVAL-BURIAL		8/27/72		CRAWFORD ST. MEMORIAL PARK	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 31 1972		Dante Manysi		6010 REGISTER TOWN ROAD	

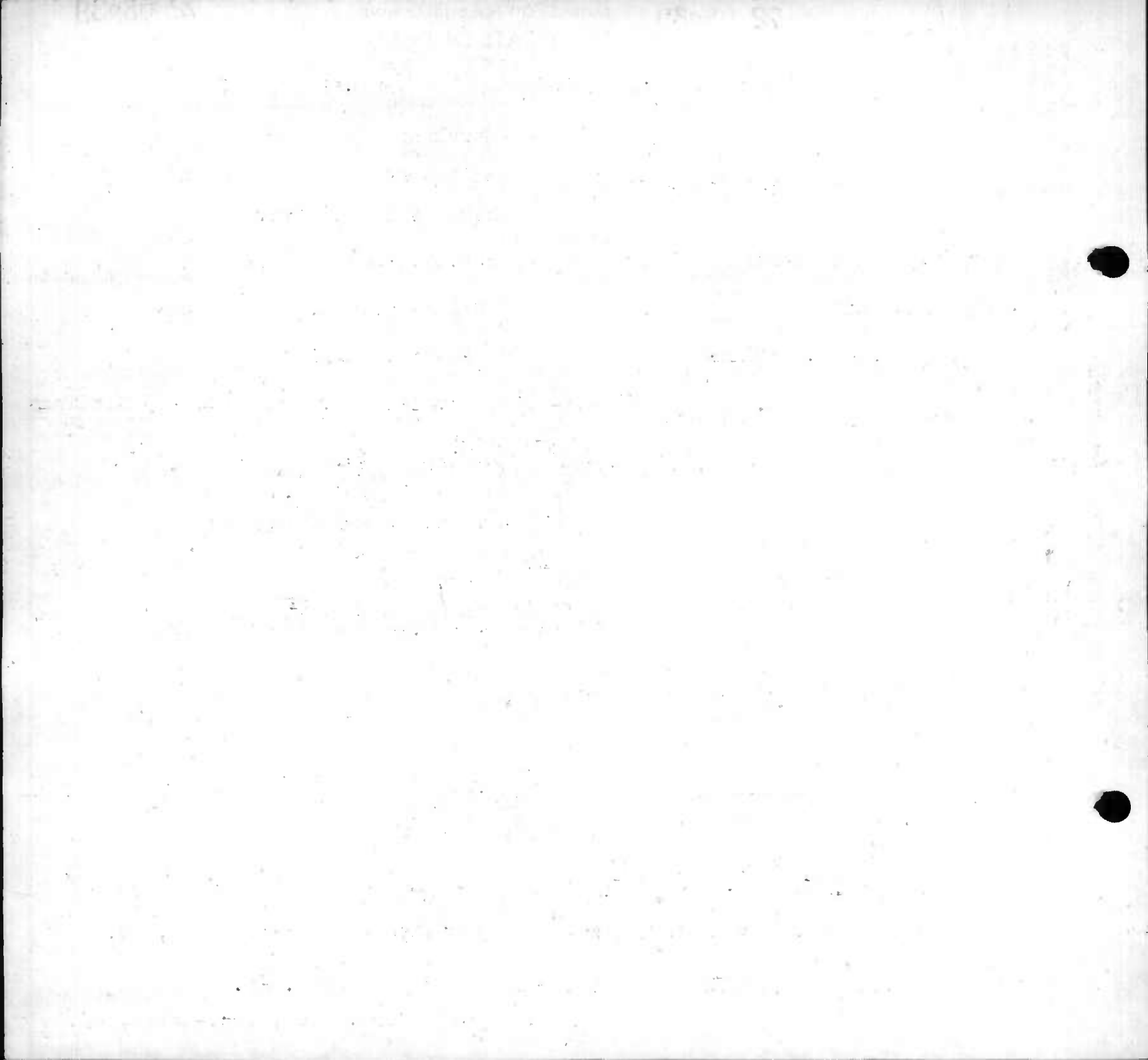
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
72 08339				72 08339
BIRTH NO.				STATE OF MARYLAND-DEME
1. NAME OF DECEASED (Type or Print)		HELEN GERTRUDE VOGEL		2. DATE AND HOUR OF DEATH August 27, 1972
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  00 2401 Hamilton Avenue		A. STATE Maryland B. COUNTY 2706 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2401 Hamilton Ave.		
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 17, 1900	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William T. McGlone		
14. MOTHER'S MAIDEN NAME Anna L. Collins		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 213-74-0228		17. INFORMANT Mr. Joseph C. Mansueti, 1273 Gittings		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma sigmoid (B) DUE TO, OR AS A CONSEQUENCE OF: Colon & obstruction + (C) Colostomy  AS CVD - gen & arteriosclerosis		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 65 to Aug 27 1972, that (I) (we) lost saw the deceased alive on Aug 25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. Donald W. Mintzer		23B. DATE SIGNED Aug 28 1972		23C. PHYSICIAN'S NAME (Type) Dr. Donald W. Mintzer
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/30/72		24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972		
25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.-Balto, Md.		25C. FUNERAL DIRECTOR ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08340
CERTIFICATE OF DEATH				72 08340
BIRTH NO. D-524		REG. NO. STATE OF MARYLAND-DEME		
1. NAME OF DECEASED (Type or Print) <b>Anthony DiAngelo</b>		2. DATE AND HOUR OF DEATH <b>August 28, 1972</b> <b>11:05 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Edgewood Nursing Home</b> <b>90</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6208 Alta Ave</b> <b>2745</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1903</b>	
9. AGE (In years last birthday) <b>68</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired tile setter</b>		
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Anthony Peter DiAngelo</b>		14. MOTHER'S MAIDEN NAME <b>Teresa J Antiono</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-09-0710</b>		
17. INFORMANT <b>Mr James J DiAngelo</b>		ADDRESS <b>Same</b>		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ce of Lung</b>				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 10 1972</b> to <b>Aug 28 1972</b> , that (I) (we) last saw the deceased alive on <b>8/24/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Mark Dugan</b>		23B. DATE SIGNED <b>8/29/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>Mark Dugan M.D.</b>		23D. ADDRESS <b>15 E. Biddle St Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/31/72</b>		
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Lindsey Weston</b>		
25C. FUNERAL DIRECTOR <b>Leonard J Ruck I c.</b>		ADDRESS <b>Baltimore, Md</b>		



STATE OF MARYLAND-DEMD BALTIMORE CITY HEALTH DEPARTMENT				72 08341			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>CECELIA U. DRUERY</b>							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3729 Yolando Road</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 26, 1972			
3. DATE PRONOUNCED DEAD Month Day Year August 26, 1972				Hour 5:48 P.M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>903</b>							
6. SEX <b>Female</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Nov. 6, 1896</b>		10. AGE (In years lost birthday) <b>75</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF <b>USA</b>		13. FATHER'S NAME <b>Frederick Schmidt</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		15. MOTHER'S MAIDEN NAME <b>Kunigunda ?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-09-1810</b>		18. INFORMANT <b>Mrs. Ursula Seluzicki</b>		ADDRESS <b>3104 Echodale Ave.</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>				CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>August 27, 1972</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/30/72.</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Lidny</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md.</b>			

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE  
FROM: [illegible]  
SUBJECT: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]

4. [illegible]  
5. [illegible]  
6. [illegible]

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11. [illegible]  
12. [illegible]

13. [illegible]  
14. [illegible]  
15. [illegible]

16. [illegible]  
17. [illegible]  
18. [illegible]

19. [illegible]  
20. [illegible]  
21. [illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

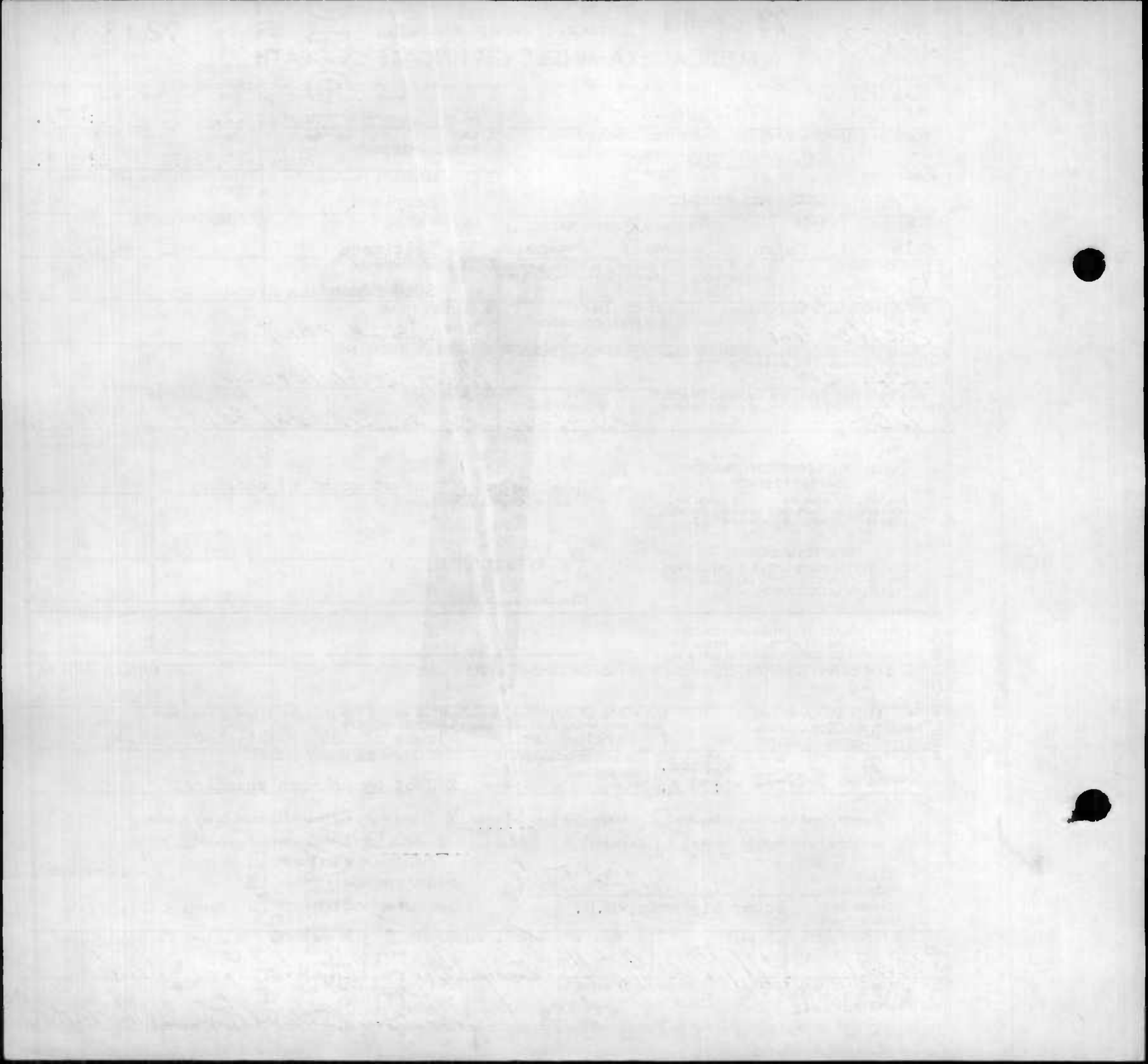
HEALTH DEPARTMENT		REG. NO. 72 08312	72 08312	
BIRTH NO. 4-240		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Gertrude R Heckel</b>		2. DATE AND HOUR OF DEATH <b>August 25, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>  4211 Heckel Ave		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2731</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4211 Heckel Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1924</b>	9. AGE (In years last birthday) <b>47</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Legal Secretary</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>James C Morgereth</b>		14. MOTHER'S MAIDEN NAME <b>Margaret A Marx</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-2200</b>		17. INFORMANT <b>Mr Albert L Heckel</b>
				ADDRESS <b>Same</b>
18. <b>17229 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Metastatic Malignant Melanoma</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>8/17</b> <b>4/22</b> 19 <b>72</b> to <b>8/25</b> 19 <b>72</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>8/17</b> 19 <b>72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) (did) (did not) view the body after death.				
23A. SIGNATURE <b>L.B. Stevens</b>		23B. DATE SIGNED <b>8/26/72.</b>		23C. PHYSICIAN'S NAME (Type) <b>L.B. Stevens M.D.</b>
23D. ADDRESS <b>3400 Erdman Ave Baltimore, Maryland</b>		23E. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Baltimore, Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/29/72.</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		
25B. NAME OF REGISTRAR <b>Lidney Whorton</b>		25C. NAME OF REGISTRAR <b>Lidney Whorton</b>		



BALTIMORE

RE CITY

STATE OF MARYLAND - DEPT. OF HEALTH BALTIMORE CITY HEALTH DEPARTMENT				72 08343	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) LOUIS DURANT			2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> August 27, 1972 3:00 A.M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital			3. DATE PRONOUNCED DEAD Month Day Year Hour August 27, 1972 3:00 A.M.		
6. SEX Male			5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1606		
7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH July 26, 1942		10. AGE (In years last birthday) 30		E. STREET AND NUMBER 3018 Edmondson Avenue	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Louis Durant	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reporter		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Martha Anderson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 212-40-3043		18. INFORMANT Martha Durant 3018 Edmondson Ave	
19. E 965X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE Gunshot wound of abdomen DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Parking lot		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? rear of 630 Franklinton Road 1606	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 8-27-72 1:20 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 27, 1972 ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/1/72		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Ceder Hill Md		25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR Lindsey Houston	
25C. FUNERAL DIRECTOR		25D. ADDRESS 3198 N. Howard St			



72 08344

STATE OF MARYLAND  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08344

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>HATTIE CORNELUIS</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> August 26, 1972 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour August 26, 1972 8:41 A. M.			
6. SEX Female				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Nov. 4, 1905</b>				10. AGE (In years last birthday) <b>66</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>JOHNNY Burrell</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				15. MOTHER'S MAIDEN NAME <b>Mary Baines</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				17. SOCIAL SECURITY NO. <b>912-46-8453</b>		18. INFORMANT <b>Benedicta Louden</b> ADDRESS <b>503 N. Arlington Ave</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>0</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovid, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 27, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/30/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE RECEIVED BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>John J. Brown</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>319 N. Schrock</b>	

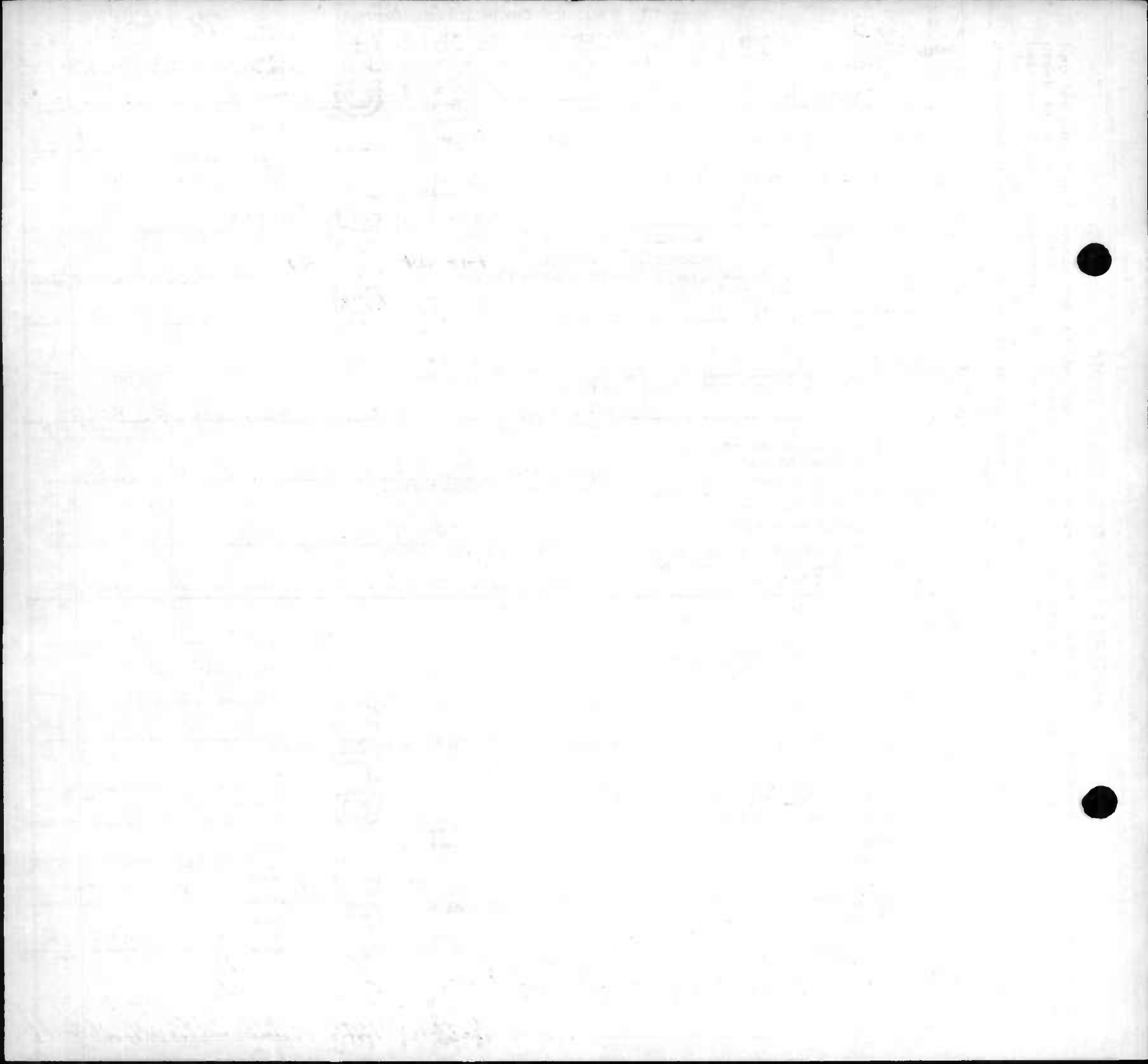
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08245	
D-243 72 08245				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Helen L. De Shields</u>		2. DATE AND HOUR OF DEATH <u>8-29-72</u> <u>1:30</u> <u>P.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2047</u>		STATE OF <u>MARYLAND</u> - <u>DEPT</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> <u>34</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-18-21</u>		9. AGE (In years last birthday) <u>51</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>James Nichols</u>	
14. MOTHER'S MAIDEN NAME <u>Lottie Houston</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-26-1317</u>	
17. INFORMANT <u>Chart</u>		ADDRESS <u>Bon Secours Hosp.</u>		18. <u>33441</u> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized peritonitis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
(B) <u>Obstruction of right lower peritoneum</u>		DUE TO, OR AS A CONSEQUENCE OF: <u>days</u>		(C) <u>Status post remote gastropneumostomy for ulcer</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Edema of gastropneumostomy site</u>		DUE TO, OR AS A CONSEQUENCE OF: <u>days</u>		MEDICAL CERTIFICATION	
19A. DATE OF OPERATION <u>8/9/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Polyp of colon</u>		20A. AUTOPSY (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>8/1</u> 19 <u>72</u> to <u>8/29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. E. Lee M.D.</u>		23B. DATE SIGNED <u>8-29-72</u>		23C. PHYSICIAN'S NAME (Type) <u>HOA. SUNG LEE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/1/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. NAME OF REGISTRAR <u>Sidney Brown</u>		24F. FUNERAL DIRECTOR <u>W. J. Brown</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

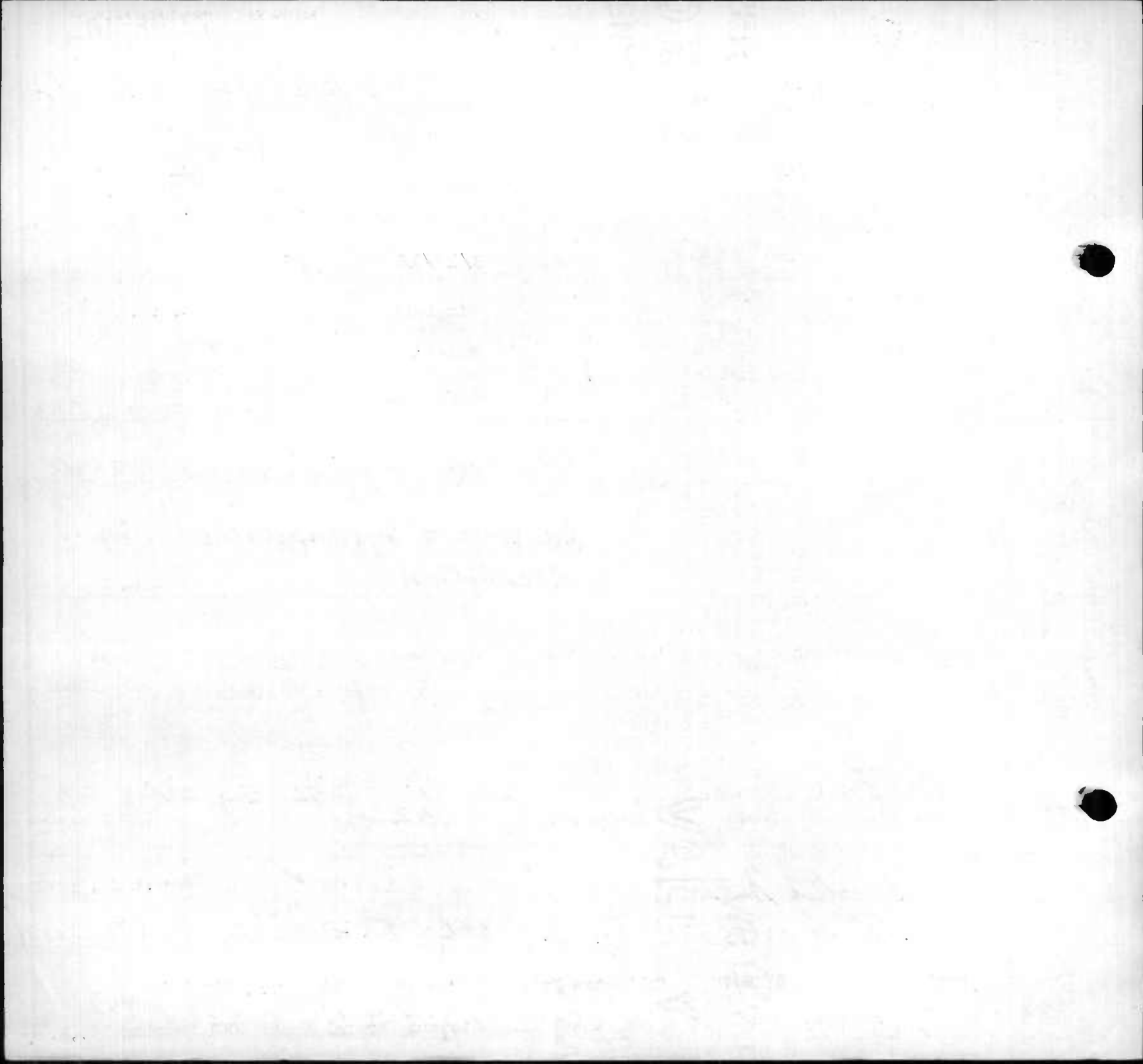




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08346	
72 08346				STATE OF MARYLAND - DMD	
1. NAME OF DECEASED (Type or Print) <b>Jones, Sadie</b>		2. DATE AND HOUR OF DEATH <b>8/24/72 8:09 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2223 Dukeland Street 21216</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/18/16</b>	9. AGE (In years last birthday) <b>56</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John</b>		14. MOTHER'S MAIDEN NAME <b>Mattie</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>BCH: RECORDS</b> ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>carcinoma of esophagus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>low pressure hydrocephalus</b>		DUE TO, OR AS A CONSEQUENCE OF <b>Alcoholism</b>		<b>5 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>July 31</b> 19 <b>72</b> to <b>Aug 24</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Aug 24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Hiroschi Mitsumoto, M.D.</b>		23B. DATE SIGNED <b>August 24, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>HIROSHI MITSUMOTO, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/29/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arlington National Cemetery, Arlington, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney B. Wilson</b>		25C. FUNERAL DIRECTOR <b>Stevart Funeral Home</b> ADDRESS <b>4001 Benning Rd., N.W.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-340		72 08347		72 08347	
BIRTH NO.		72 08347		REG. NO.	
1. NAME OF DECEASED (Type or Print)		LITTLE, EUGENETTE		2. DATE AND HOUR OF DEATH 8/29/72 10:58 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. CITY OR TOWN DUNDALK	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10B. KIND OF BUSINESS OR INDUSTRY SHIP REPAIR		8. DATE OF BIRTH 5-22-16	
13. FATHER'S NAME JOE LITTLE		14. MOTHER'S MAIDEN NAME BERTHA SCARBORO		9. AGE (in years last birthday) 56	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 233-30-8271		11. BIRTHPLACE (State or foreign country) TENN.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST ETIOLOGY UNKNOWN (B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE MI (C) CHRONIC OBSTRUCTIVE LUNG DISEASE - 10 YRS.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 1 1/2 hrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		II			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/22 1972 to 8/29 1972 that (I) (we) last saw the deceased alive on 8/29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Kraus M.D.				23B. DATE SIGNED 8/29/72	
23C. PHYSICIAN'S NAME (Type) John W. Kraus M.D.				23D. ADDRESS 601 N. Broadway - Balt. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/1/72		24C. NAME OF CEMETERY OR CREMATORY SUNSET MEM. CEM	
24D. LOCATION BECKLEY, W. VA.		25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972			
25B. NAME OF REGISTRAR Andrew [Signature]		25C. FUNERAL DIRECTOR [Signature]			

DEPT. OF AGRICULTURE

UNITED STATES

WASHINGTON

FUNERAL DIRECTOR: IMPORTANT

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S-5361

72 08348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72 08348

STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LILLIAN SCHNEIDER

2. DATE AND HOUR OF DEATH

8/29/72

1:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
MARYLAND

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

3900 PARKVILLE DR.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

Female Caucasian

6. RACE

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

4-1-11

9. AGE (In years last birthday)

61

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

JACOB BLACK

14. MOTHER'S MAIDEN NAME

MARY SCHOPPLEIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service

NO

16. SOCIAL SECURITY NO.

RIP-22-9490

17. INFORMANT

ROBERT E. SCHNEIDER, 3900 PARKSIDE DR.

ADDRESS

21206

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Prob. pulmonary embolism

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 1/2 hr

3 hr

18 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Recent coronary artery bypass

19A. DATE OF OPERATION

3/10/72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Coronary artery disease

20A. AUTOPSY (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/31 1972 to 8/29 1972 that (I) (we) lost saw the deceased alive on 8/29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Randolph M. Howes MD, PHD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

8/29/72

23C. PHYSICIAN'S NAME (Type)

RANDOLPH

M HOWES MD

23D. ADDRESS

Johns Hopkins Hospital Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2 SEPT. 72

24C. NAME OF CEMETERY OR CREMATORY

MORELAND MEMORIAL PK

24D. LOCATION

BALTO. CO., MD.

(City, town, or county)

1 State

25A. DATE REC'D BY HEALTH DEPT.

AUG 31 1972

25B. NAME OF REGISTRAR

Sidney M. Howes

25C. FUNERAL DIRECTOR

GLENN FOWLER HOME, BALTO. MD 21206

ADDRESS

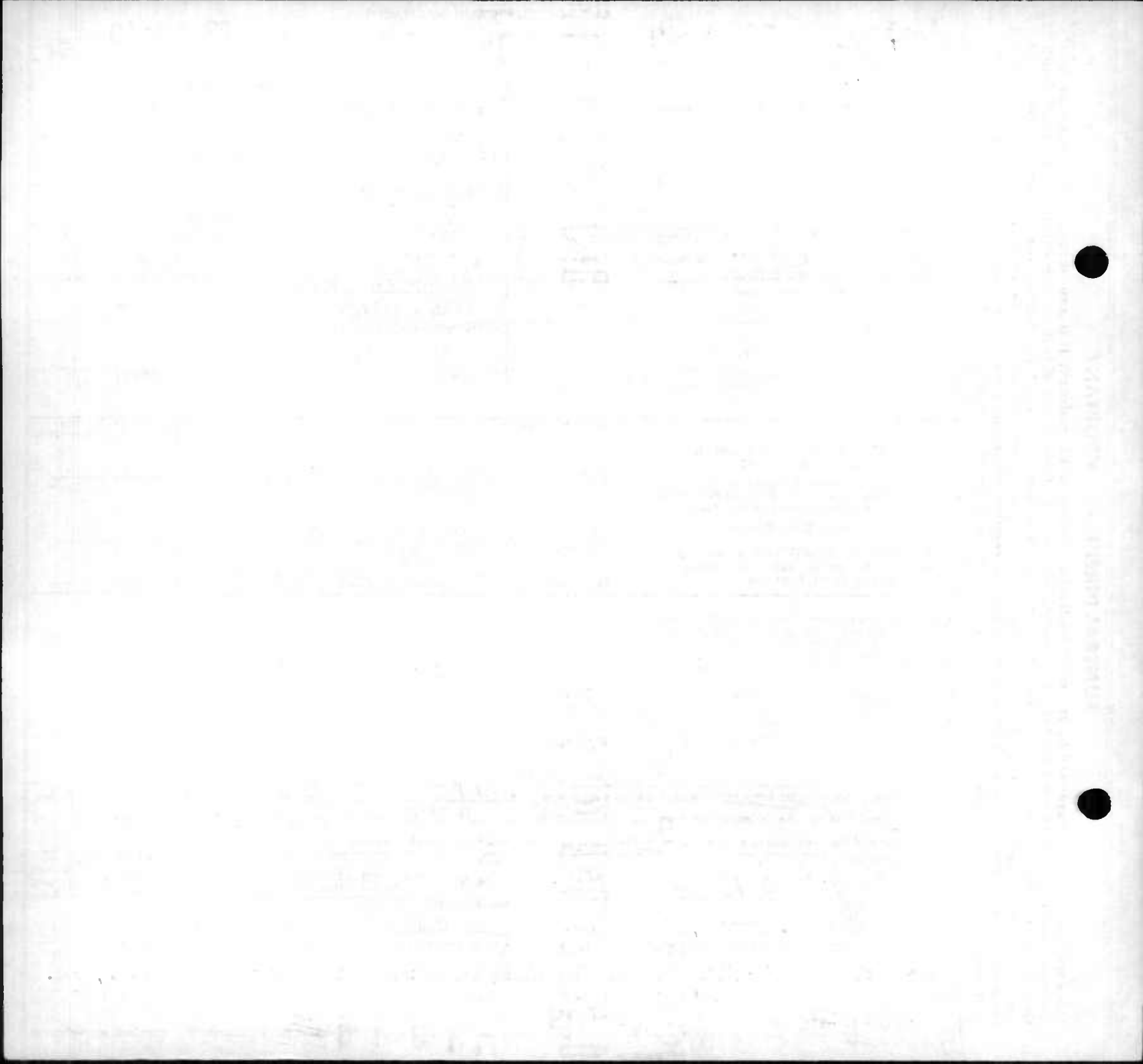
3900 PARKSIDE DR.

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08249</u>	
W-320 72 08349				STATE OF MARYLAND-DEPT	
BIRTH NO. <u>Balto. Md.</u>			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Woods, Allison</u>			2. DATE AND HOUR OF DEATH <u>8-29-72 4:30 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>			A. STATE <u>Maryland</u> B. COUNTY <u>27 48</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>			6. RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <u>8-17-72</u>			9. AGE (In years last birthday) <u>0 12</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) <u>Franklin Square Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Woods</u>			14. MOTHER'S MARDEN NAME <u>Kay Witmer</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>J</u>
18. <u>741.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>myelomeningocele</u> (C) <u>scoliosis, hydrocephalus</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-17</u> 19 <u>72</u> to <u>8-29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8-28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ralph S Brown</u> M.D. DEGREE				23B. DATE SIGNED <u>8-29-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ralph S. Brown,</u> M.D. DEGREE				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>8/29/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins Hospital</u>	
24D. LOCATION (City, town, or county) (State) <u>601 N Broadway Balto., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR <u>Lindsey Houston</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	
25D. ADDRESS					

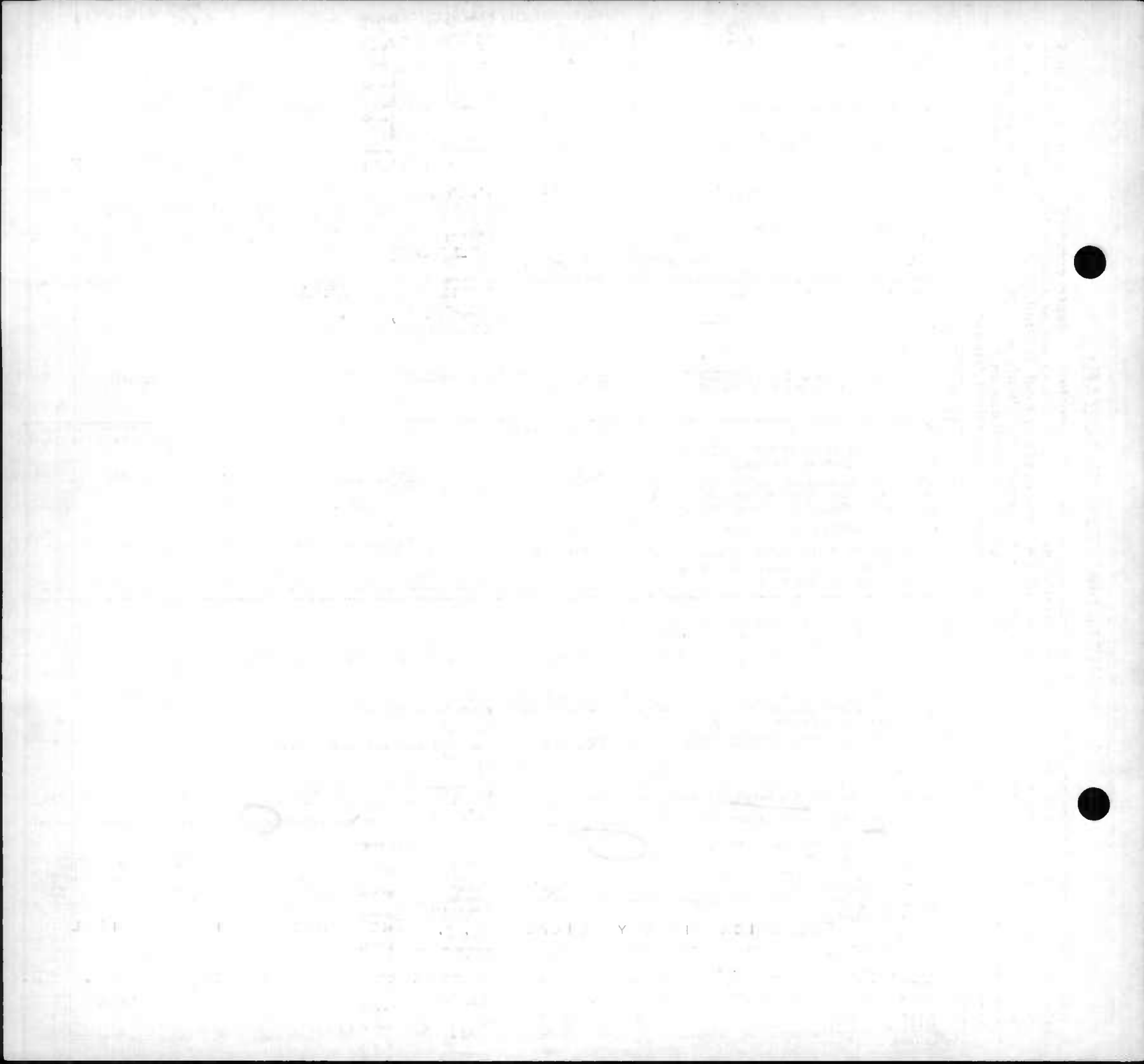




# FUNERAL DIRECTOR: IMPORTANT

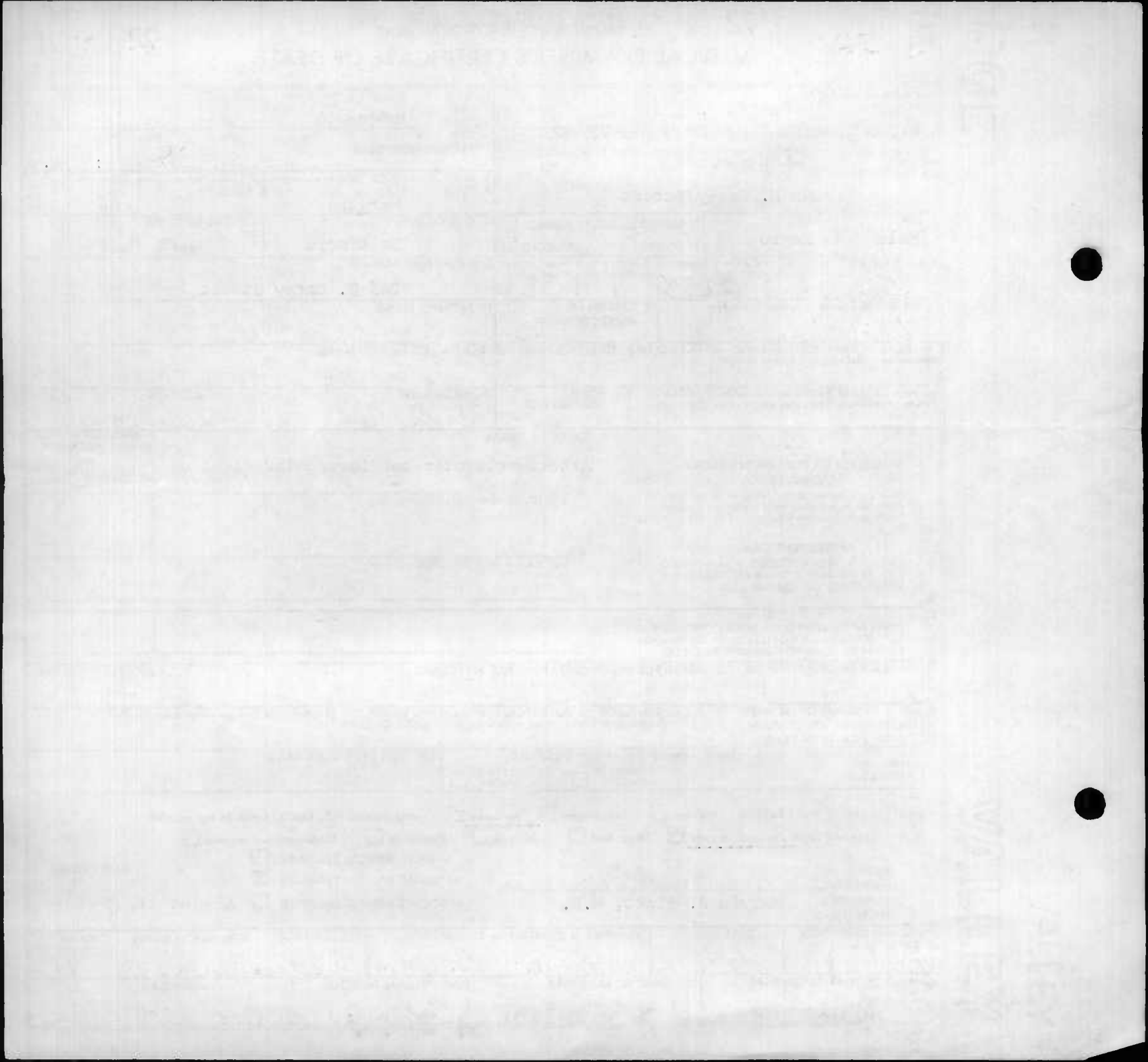
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08350	
M-300 72 08350				CERTIFICATE OF DEATH	
BIRTH NO. <u>Elkton, Md.</u>		REG. NO. <u>72 08350</u>		STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print) <u>NOTE, Baby Girl</u>		2. DATE AND HOUR OF DEATH <u>8/25/72 6:45 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Cecil</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>RISING SUN</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>LOT D 12 COUNTRY BAY ESTATES</u>			
5. SEX <u>F</u>	6. RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-72</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Union Hospital Elkton, Md.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>746.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrhythmias</u> <u>Cardio-vascular collapse</u> (B) <u>Presumed Cardiac anomalies</u> DUE TO, OR AS A CONSEQUENCE OF: <u>multiple congenital anomalies</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>22 hrs</u> <u>22 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>gastroschisis</u>					
19A. DATE OF OPERATION <u>1 8-25-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>gastroschisis</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 24</u> 19 <u>72</u> to <u>Aug 25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frederick Timothy Guilford M.D.</u>				23B. DATE SIGNED <u>8-25-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>FREDERICK TIMOTHY GUILFEND M.D.</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>8/26/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Johns Hopkins Hospital</u>	
24D. LOCATION (City, town, or county) (State) <u>601 N Broadway BALTO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR <u>Sidney H. Kohn</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>	



72 08351 ~~STATE OF MARYLAND - DEPT.~~  
BALTIMORE CITY HEALTH DEPARTMENT  
72 08351  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ISAAC JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 200 245 N. Carey Street		3. DATE PRONOUNCED DEAD Month Day Year August 24, 1972		8:30 A. M.	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5/21/14		10. AGE (In years last birthday) 58		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME ROZIER JONES		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME FLORENCE SCOTT		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT FRANK JONES		19. ADDRESS 60 S. CALVER ST.		20. DATE OF OPERATION	
21. AUTOPSY? (Yes or No) Yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
24. TIME OF INJURY (APPROX.)		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR?	
27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. ACTUAL SIGNATURE Marvin S. Platt, M.D.		29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
30. DATE SIGNED August 24, 1972		31. DATE REC'D BY HEALTH DEPT. AUG 31 1972		32. NAME OF REGISTRAR Charles A. Rice	
33. FUNERAL DIRECTOR 1300 E. Taw Pl.		34. ADDRESS		35. DATE OF DEATH 8/28/72	
36. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		37. LOCATION (City, town, or county) (State) Westport, Maryland		38. DATE OF BURIAL 8/28/72	

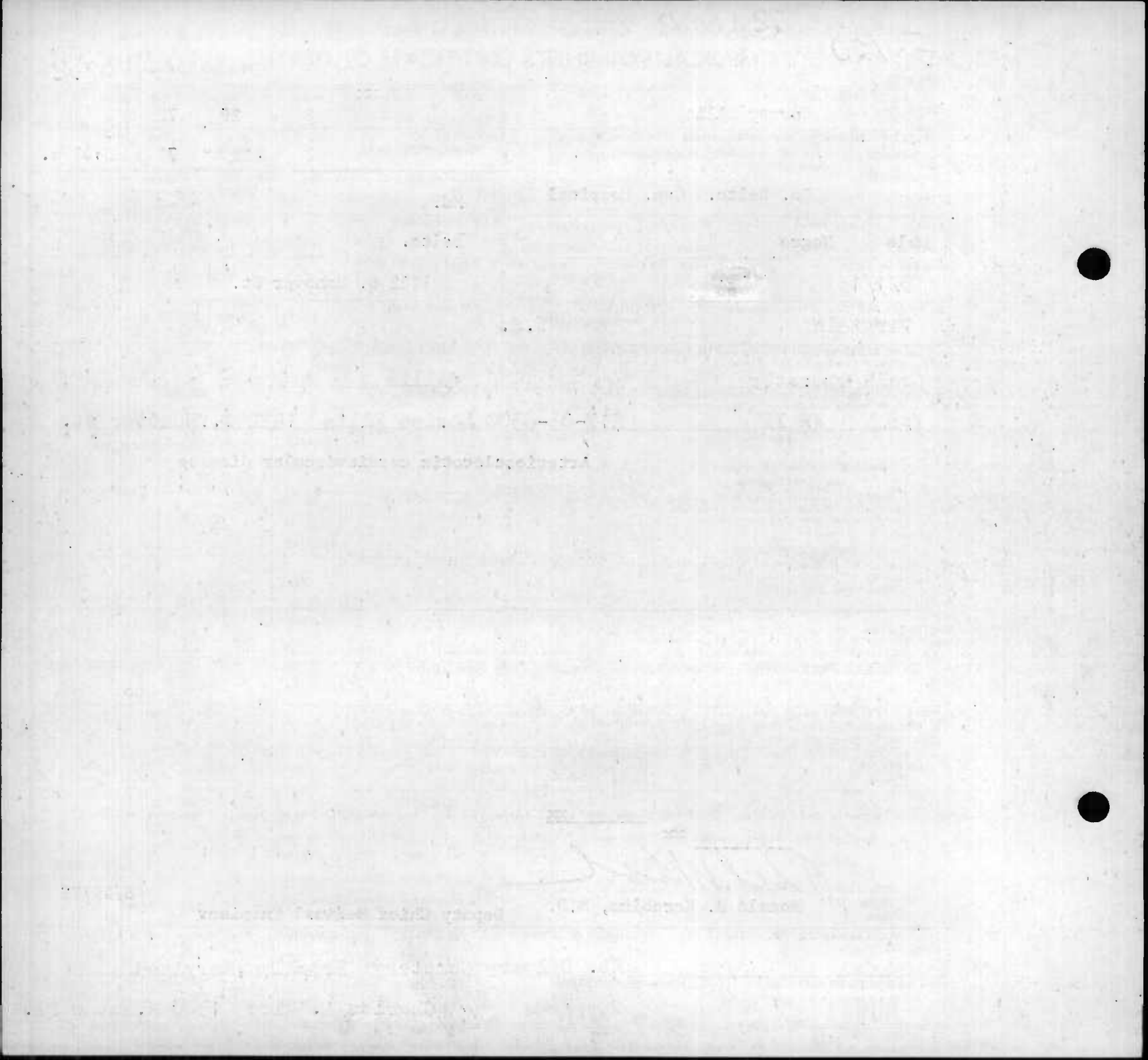


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08352

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harvey Ellis		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 8	Day 29	Year 72	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 So. Balto. Gen. Hospital		3. DATE PRONOUNCED DEAD Month 8 Day 29 Year 72		Hour 5:47 a.		M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2301		6. SEX male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5/1/13		10. AGE (In years) 59		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crain Operater		15. MOTHER'S MAIDEN NAME Sallie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II	
17. SOCIAL SECURITY NO. 217-03-8300		18. INFORMANT Louise Ellis		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		20. ADDRESS 1222 S. Hanover St.	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25. DATE OF OPERATION 9/2/72		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? (Yes or No) no		28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		31. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)		32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
33. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		35. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner		36. DATE SIGNED 8/29/72	
37. BURIAL CREMATION, REMOVAL (Specify) Burial		38. DATE 9/2/72		39. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		40. LOCATION (City, town, or county) (State) Brooklyn, Maryland	
41. DATE REC'D BY HEALTH DEPT. AUG 31 1972		42. NAME OF REGISTRAR Sidney B. Watson		43. FUNERAL DIRECTOR Charles A. Rice		44. ADDRESS 1300 N. Eutaw Pl.	





M-460

72 08353

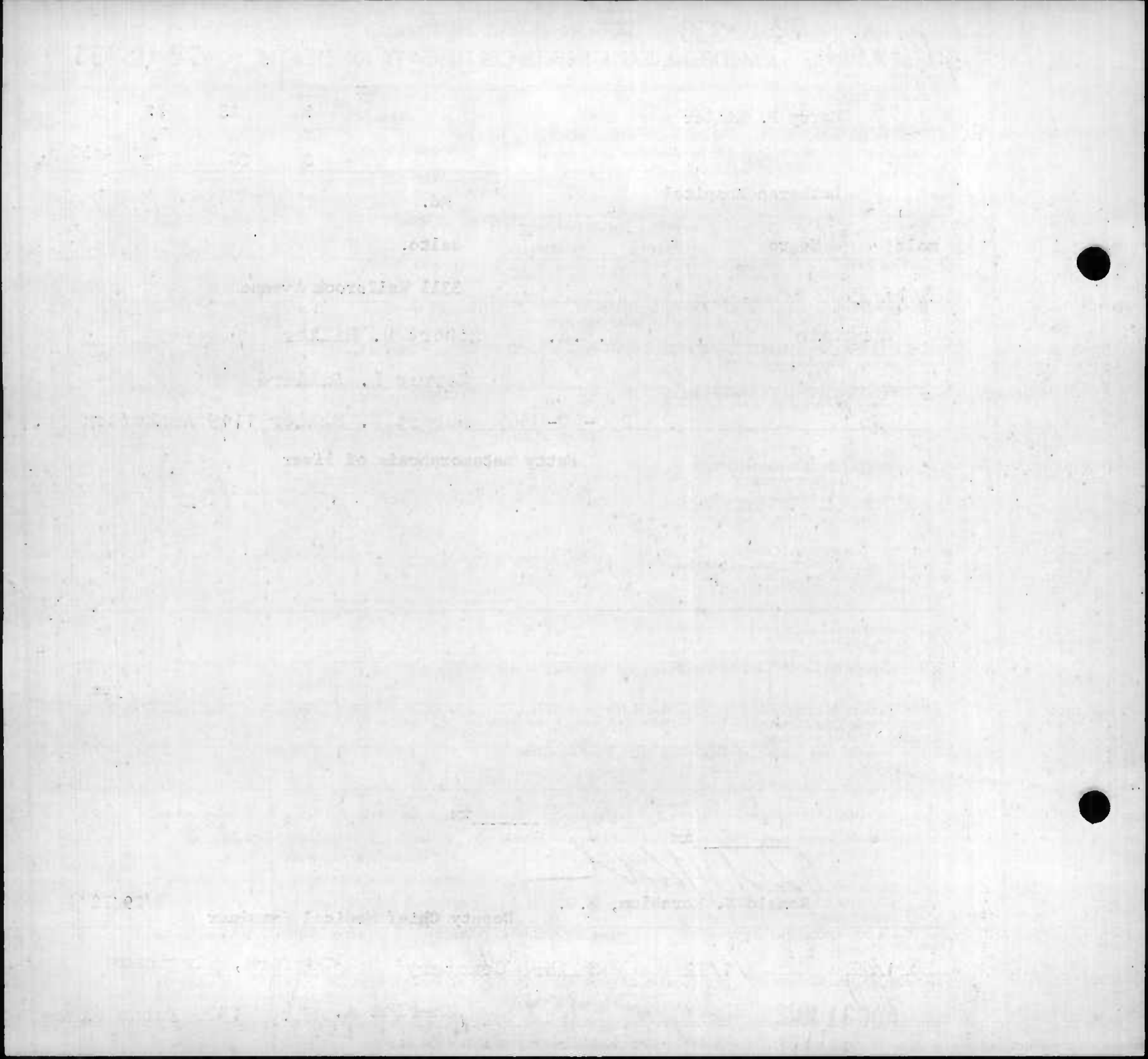
STATE OF MARYLAND-DEME  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08353

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Harry P. Miller</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>8</b> Day <b>28</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>28</b> Year <b>72</b> Hour <b>4:30</b> P. <b>M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1506</b>			
6. SEX <b>male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>8/16/35</b>		10. AGE (In years last birthday) <b>37</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert H. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Carrie L. Dillard</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>230-40-0367</b>	
19. CAUSE OF DEATH <b>571.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. DATE OF OPERATION <b>2</b>		22. CONDITION FOR WHICH OPERATION WAS PERFORMED	
23. AUTOPSY? (Yes or No) <b>yes</b>			
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
27. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
29. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner	
DATE SIGNED <b>8/29/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/1/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Miller Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Guyfork, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		25D. ADDRESS <b>1300 Eutaw Place</b>	



A-450

72 08354

STATE OF MARYLAND-DHMH  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08354

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WALKER Thomas Allen</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 24 72 8:41 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 24 72 8:41 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore,	
9. DATE OF BIRTH 10. AGE (in years lost birthday) 36		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) FARMVILLE Va		E. STREET AND NUMBER 1804 N. Eutaw Street	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME UNK	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME QUEEN V. WALKER	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT REID FUNERAL HOME		ADDRESS FARMVILLE Va.	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 882X		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Subdural hematoma DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 8 23 72 8:30 P.M.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1804 N. Eutaw Street	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell 10' from porch to concrete pavement	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8-25-72	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 8-26-72	
24C. NAME OF CEMETERY or CREMATORY OAK GROVE BAPTIST CHURCH		24D. LOCATION (City, town, or county) (State) FARMVILLE Va.	
25A. DATE RECEIVED BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR REID FUNERAL HOME FARMVILLE	
25C. FUNERAL DIRECTOR REID FUNERAL HOME FARMVILLE		25D. ADDRESS FARMVILLE Va.	

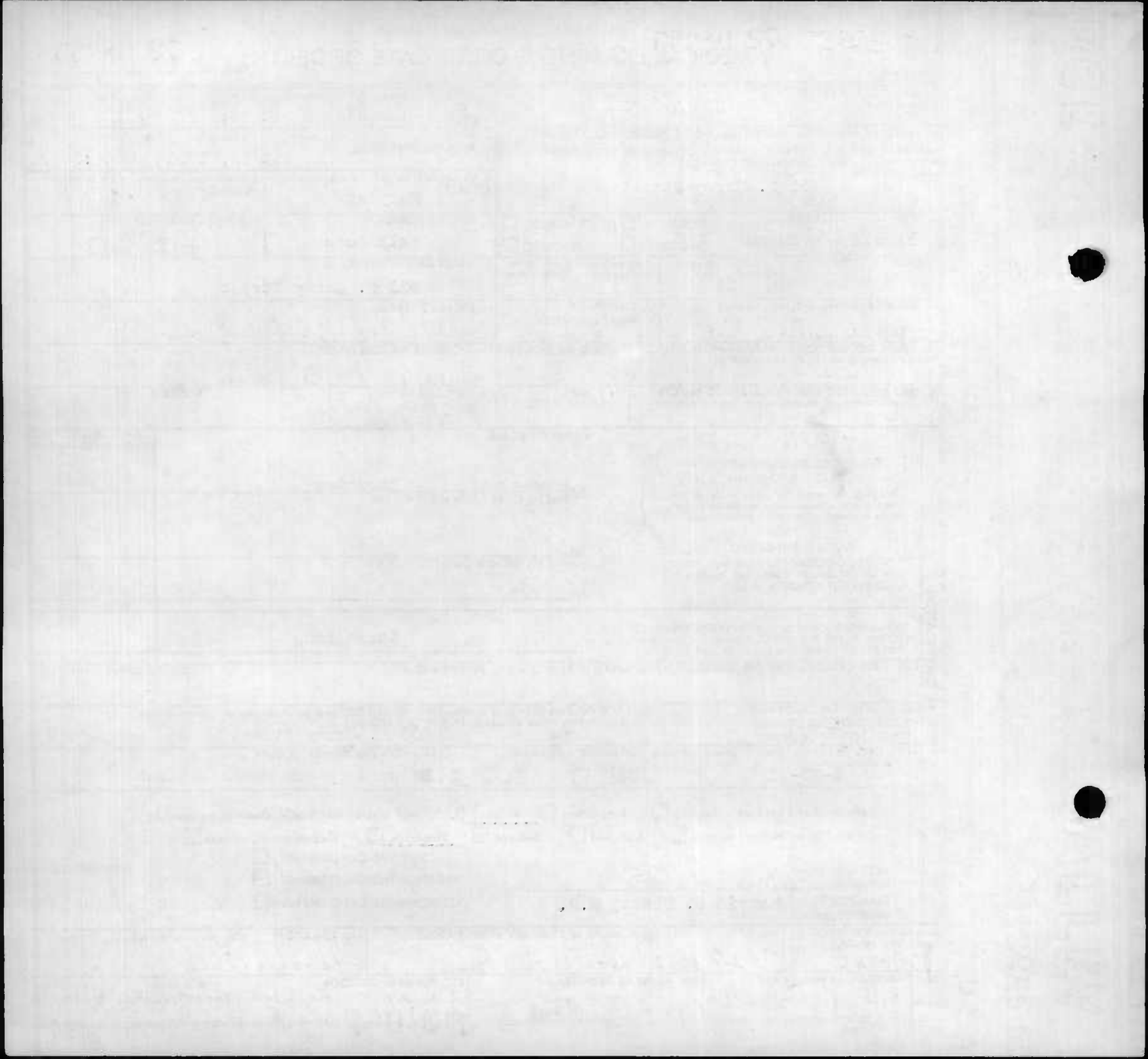


B-535 72 08355

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08355

1. NAME OF DECEASED (Type or Print) <b>BERNETHA BENTON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>August 23, 1972</b>		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>633 N. Carey Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 23, 1972</b>		Hour <b>11:30 P.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) <b>25</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Willie D. Benton</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
15. MOTHER'S MAIDEN NAME <b>Susie Benjamin</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Marthey Jacobs</b>		19. CAUSE OF DEATH <b>E 9641 X</b>		20. ADDRESS <b>SA me</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Drowning</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Strangling</b>			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>633 N. Carey Street</b>	
22D. TIME OF INJURY (APPROX.) <b>8-23-72 ?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Browned by unknown assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Marvin S. Platt</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Marvin S. Platt, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>August 24, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-28, 1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Washington Co.</b>	
24D. LOCATION (City, town, or county) (State) <b>Washington S.C.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Johnson</b>	
25C. FUNERAL DIRECTOR <b>E. Henry O. Wilson</b>		25D. ADDRESS <b>1000 Brantley Ave. Md.</b>		25E. <b>Funeral Home</b>	





S-53572

08256

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08256

REG. NO.

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>FRANCES SNOWDEN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) OR INSTITUTION <b>48 Md. Gen. Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 27 1972 9:40 p.m.</b>	
6. SEX <b>female</b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2101</b>	
7. RACE <b>negro</b>		C. CITY OR TOWN <b>Balto.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Jan. 30 - 1922</b>		E. STREET AND NUMBER <b>622 Fremont St.</b>	
10. AGE (In years lost birthday) <b>50</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Isaac Snowden</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		15. MOTHER'S MAIDEN NAME <b>ELLA Thomas</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>220-03-4322</b>	
18. INFORMANT <b>McLores Scales</b>		ADDRESS <b>SAME</b>	
19. CAUSE OF DEATH <b>2887 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Massive cerebral hematoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unknown</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unknown</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>about 8-27-72 ? m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Probably fell</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8-28-72</b>	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-31-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Catholic Bur</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Richard Wood</b>		ADDRESS <b>Baltimore</b>	

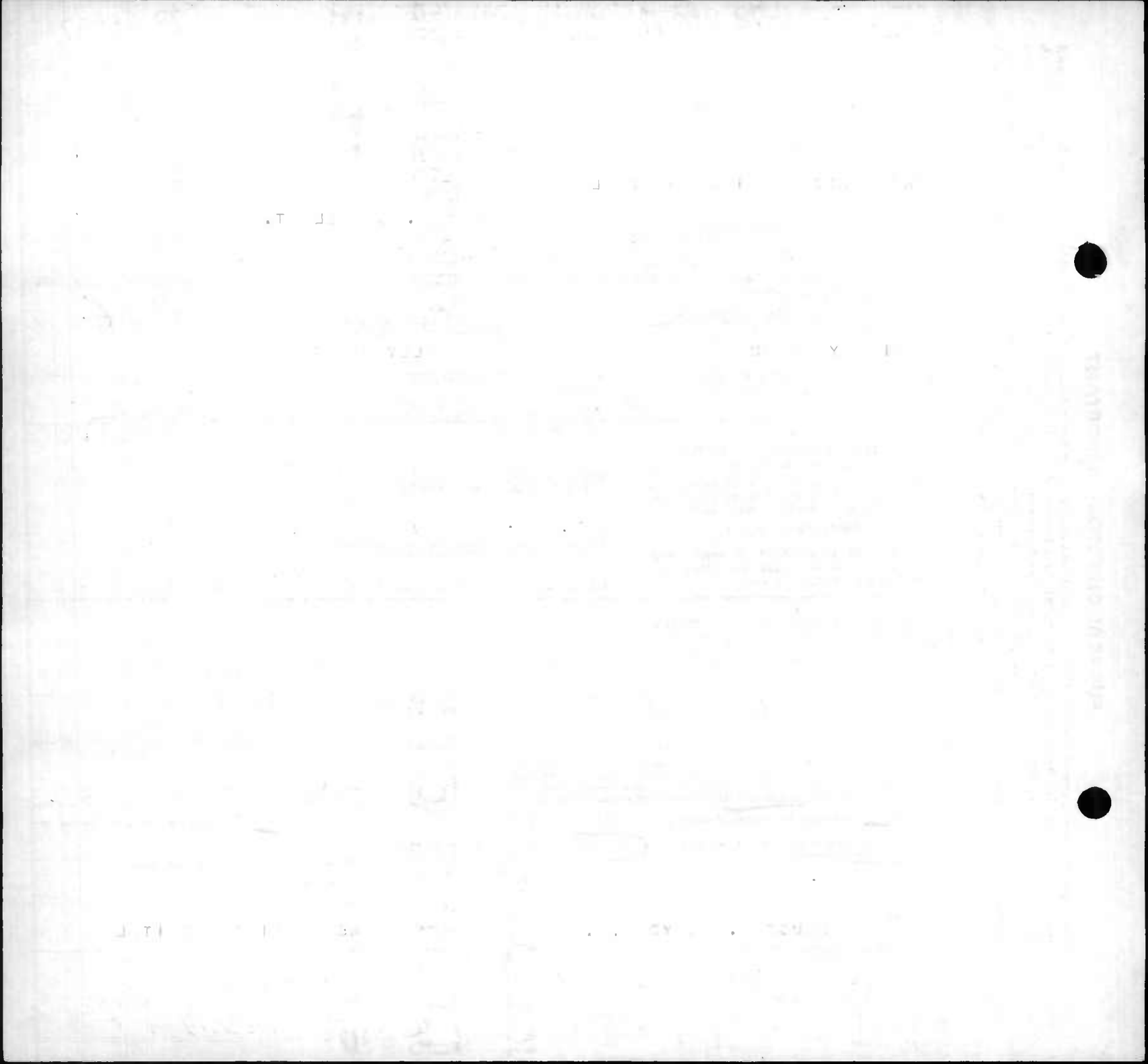


9-25-1972 - Completion of cause of death on a pending medical examiner death  
certificate - Russell S. Fisher, M.D. HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 72 08357		BALTIMORE CITY HEALTH DEPARTMENT		72 08357	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. STATE OF MARYLAND-DEMO	
1. NAME OF DECEASED (Type or Print) <b>FRANK BROWN</b>		2. DATE AND HOUR OF DEATH <b>Aug 24, 1972 11:55 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>604</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>402 N. CHAPEL ST.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>03-31 06</b>	9. AGE (In years last birthday) <b>66</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>SIDNEY BROWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>M</b>		16. SOCIAL SECURITY NO. <b>21405-7448</b>		17. INFORMANT <b>Odell Brown Same</b>	
18. <b>43101</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b>	
		(B) <b>SEVERE HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>40 years</b>	
		(C) <b>MASSIVE Cerebral Hemorrhage</b>		<b>2 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 22</b> 19 <b>72</b> to <b>Aug 24</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Aug 24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Bruce K. Floyd MD</b>				23B. DATE SIGNED <b>Aug 24, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>BRUCE K. FLOYD M.D.</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8-28-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>ARBUTUS NEW PK</b>	
24D. LOCATION (City, town, or county) (State) <b>ARBUTUS MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>			
25B. NAME OF REGISTRAR <b>Andrew H. Wilson</b>		25C. FUNERAL DIRECTOR <b>FOR O. WILSON FH</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
72 08358					REG. NO. 72 08358					
S-300					STATE OF MARYLAND-DEMD					
1. NAME OF DECEASED (Type or Print) <u>Mabel Scott</u>					2. DATE AND HOUR OF DEATH <u>8-23-72</u> <u>11:23</u> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>					4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>901</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>931 E. 41st. Street</u>					
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/04</u>		9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>William Scott</u>			14. MOTHER'S MAIDEN NAME <u>Matilda Wilkerson</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>			16. SOCIAL SECURITY NO. <u>213-09-5110</u>		17. INFORMANT <u>Ada Taylor Gane</u>				ADDRESS	
18. <u>5-822X1</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE <u>Asystole</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest +</u> (B) <u>acute tubular necrosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>chronic renal failure</u>					<u>0:00</u> <u>3.3 hours</u> <u>&gt; 4 months</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>7-31-72</u> 19 <u>72</u> to <u>8-23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8-23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Gail Ahumada, M.D.</u>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>8-23-72</u>		
23C. PHYSICIAN'S NAME (Type) <u>GAIL AHUMADA</u>					23D. ADDRESS <u>Johns Hopkins Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>8-28-72</u>			24C. NAME of CEMETERY or CREMATORY <u>Northwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>			25B. NAME OF REGISTRAR <u>Lidney Robinson</u>			25C. FUNERAL DIRECTOR <u>8000 1000 Broadway</u>				

CHIEF OF POLICE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-635				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08359	
72 08359				CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) Roy Worham				2. DATE AND HOUR OF DEATH 8/24/72 5:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY Hosp				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY Balt C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2507 WPRATT ST Balt			
5. SEX M	6. RACE Black	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/67	9. AGE (In years last birthday) 67	10. Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Josh Worham			
14. MOTHER'S MAIDEN NAME ARNISHA (?)				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 719-10-2232				17. INFORMANT Wife Same			
18. CAUSE OF DEATH 150X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Gastritis + cervical esophagitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 8/22/72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Total Esophageal obstruction		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1972 to 8/24/72, that (I) (we) last saw the deceased alive on 8/24/72, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard L. Sylva						23B. DATE SIGNED 8/24/72	
23C. PHYSICIAN'S NAME (Type) DEGREE				23D. ADDRESS DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 8-29-72		24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR Sidney Johnston		25C. FUNERAL DIRECTOR Elroy A. Wilson		ADDRESS 1100 BRANTLEY AVE	

114-10-3332

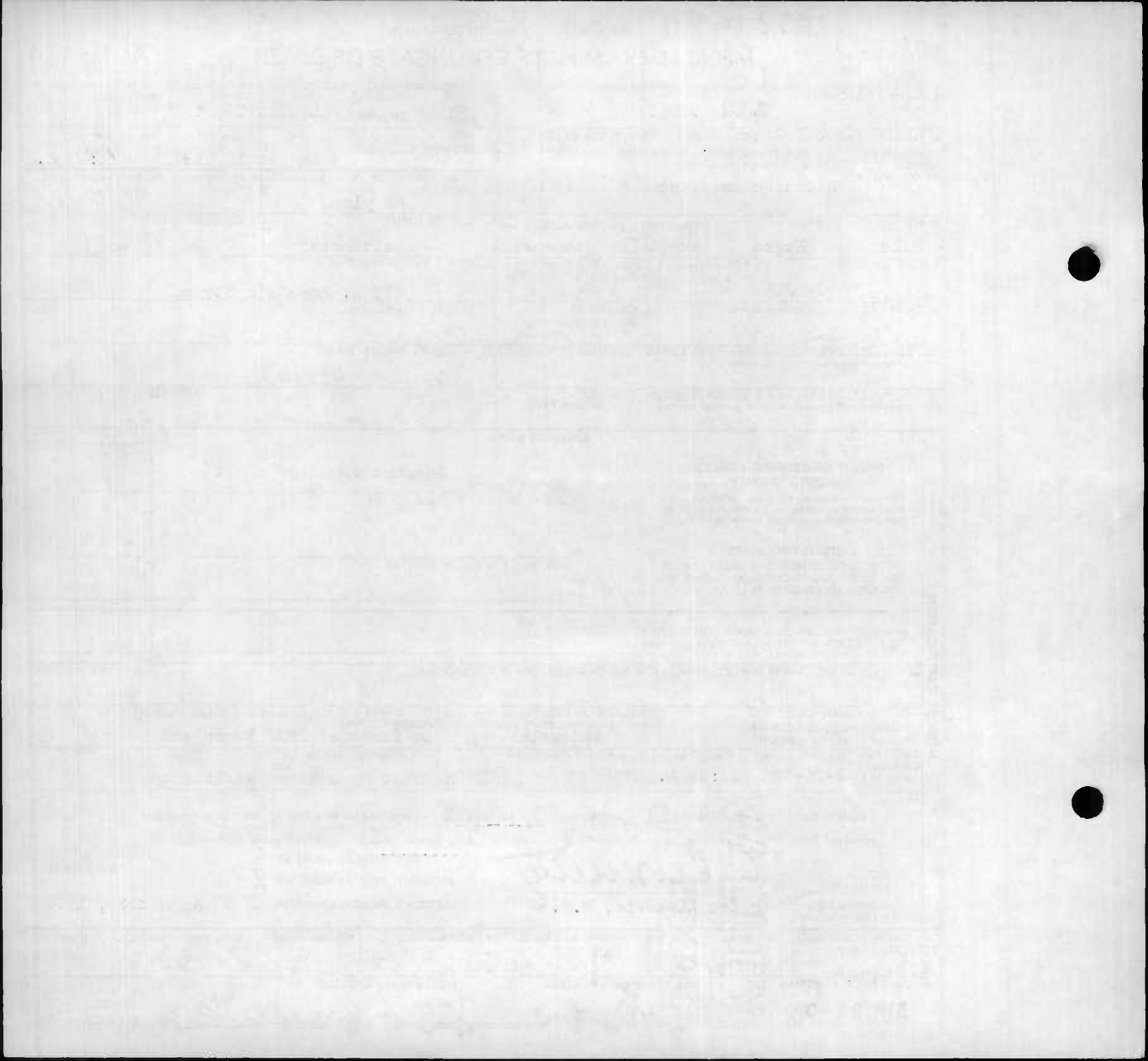


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08360

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LEON VENNEY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 26, 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year August 26, 1972		Hour M. 1:15 A.M.	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>June 19-1952</b>		10. AGE (In years lost birthday) 20		11. BIRTHPLACE (State or foreign country) <b>Richmond Va</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Leon Johnson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Virginia Venay</b>	
15. MOTHER'S MAIDEN NAME <b>Virginia Blue</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Madeline Blue</b>		19. CAUSE OF DEATH <b>E965 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of chest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>sidewalk</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>In front of 2838 Edmondson Avenue 1606</b>	
22D. TIME OF INJURY (APPROX.) 8-26-72 12:59 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 26, 1972 ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-31-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Catholic Cat</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Richardson</b>	
25C. FUNERAL DIRECTOR <b>Richardson 1000 Crumley</b>		ADDRESS			

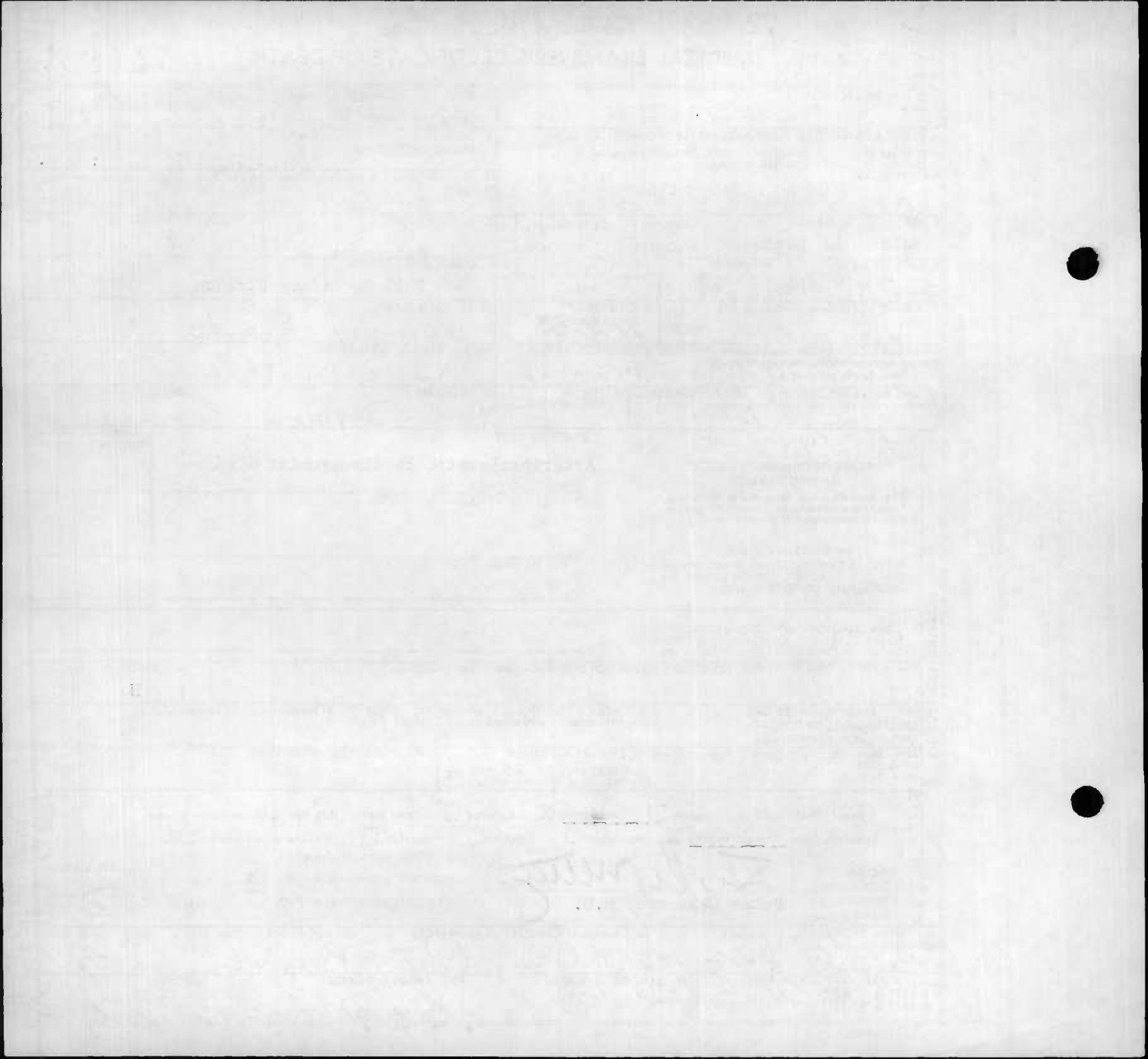


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08361

BIRTH NO.

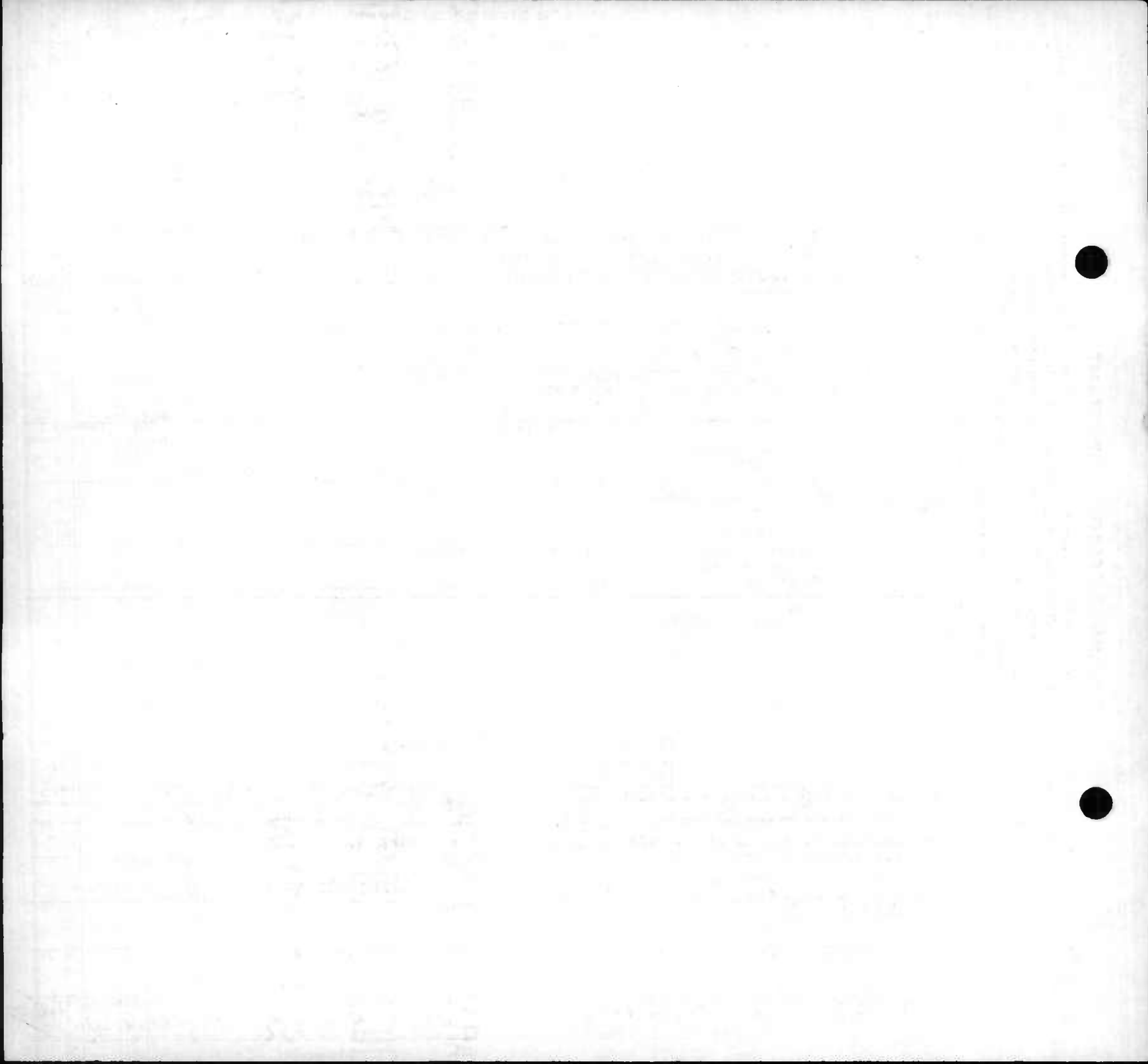
1. NAME OF DECEASED (Type or Print) <b>CHAMPION FIELDS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 27, 1972		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2025 Mc Eldery Street</b>		3. DATE PRONOUNCED DEAD Month Day Year August 27, 1972		Hour 8:05 A.M.
6. SEX Male		7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept 16, 1912		10. AGE (In years last birthday) 60	11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? None		13. FATHER'S NAME Pompey Fields		14. MOTHER'S MAIDEN NAME Susie Butts
15. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		B. COUNTY 604		C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2025 Mc Eldery Street		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Bernie Jordan
19. 41241 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 27, 1972 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8-30-72		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary
24D. LOCATION (City, town, or county) Brooklyn		24E. (State) MD		
25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR L. J. Johnson		25C. FUNERAL DIRECTOR E. J. Wilson
ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08362	
P-000 72 08362 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>PUE EMMA</u>		2. DATE AND HOUR OF DEATH <u>Aug. 24, 1972</u> <u>11:30</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1505</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hospital Complex</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>3-22-06</u>		9. AGE (in years last birthday) <u>66</u>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Rice</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rennie</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>911-18-9071</u>		17. INFORMANT <u>Anna Rennie</u> ADDRESS <u>Small</u>	
18. <u>161.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic Laryngeal Ca.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 20</u> 19 <u>72</u> to <u>Aug 24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Maurice A. Allbaugh, M.D.</u> DEGREE				23B. DATE SIGNED <u>8/24/72</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8-29-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>ARBUTUS MEM. PARK</u>	
24D. LOCATION (City, town, or county) <u>ARBUTUS MD.</u>		24E. STATE (State) <u>MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR <u>Dorothy H. Hinton</u>		25C. FUNERAL DIRECTOR <u>Gray O. Wilson</u> ADDRESS <u>1000 BRANTLEY AVE</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>(ESTHER)</b> <b>Esther Murray</b>				2. DATE AND HOUR OF DEATH <b>8/29/72 7AM</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>33</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>804</b>				C. CITY OR TOWN <b>Baltimore</b>			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <b>2324 E. Biddle St.</b>							
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>02/09/11</b>		9. AGE (In years last birthday) <b>62</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Hezekiah Murray</b>				14. MOTHER'S MAIDEN NAME <b>Walker, Delra</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Dawn Hockley</b>			
ADDRESS <b>925 Gelling Ave. Balt.</b>											
18. <b>427.01</b>				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardio respiratory arrest</b>				<b>5'</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Uremia, intractable</b> DUE TO, OR AS A CONSEQUENCE OF:				<b>Oct 71</b>			
				(C) <b>Congestive Heart failure</b>				<b>1963</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>Liver Failure</b>							
19A. DATE OF OPERATION <b>None</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>				20A. AUTOPSY? (Yes or No) <b>NO</b>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>None</b>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>None</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>None</b>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> <b>None</b>				21F. HOW DID INJURY OCCUR? <b>None</b>			
22. I certify that (1) (this hospital) attended the deceased from <b>8/18/72</b> 19 <b>72</b> to <b>8/29</b> 19 <b>72</b> , that (2) (we) last saw the deceased alive on <b>8/29</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>J. W. Richardson, MD.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>8/29/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>J. W. RICHARDSON</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9-2-72</b>				24C. NAME OF CEMETERY <b>Balt. Cemetery</b>			
24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>											
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>				25B. NAME OF REGISTRAR <b>Audrey Whitson</b>				25C. FUNERAL DIRECTOR <b>Edouard / 1000 Chantilly Dr</b>			
ADDRESS											

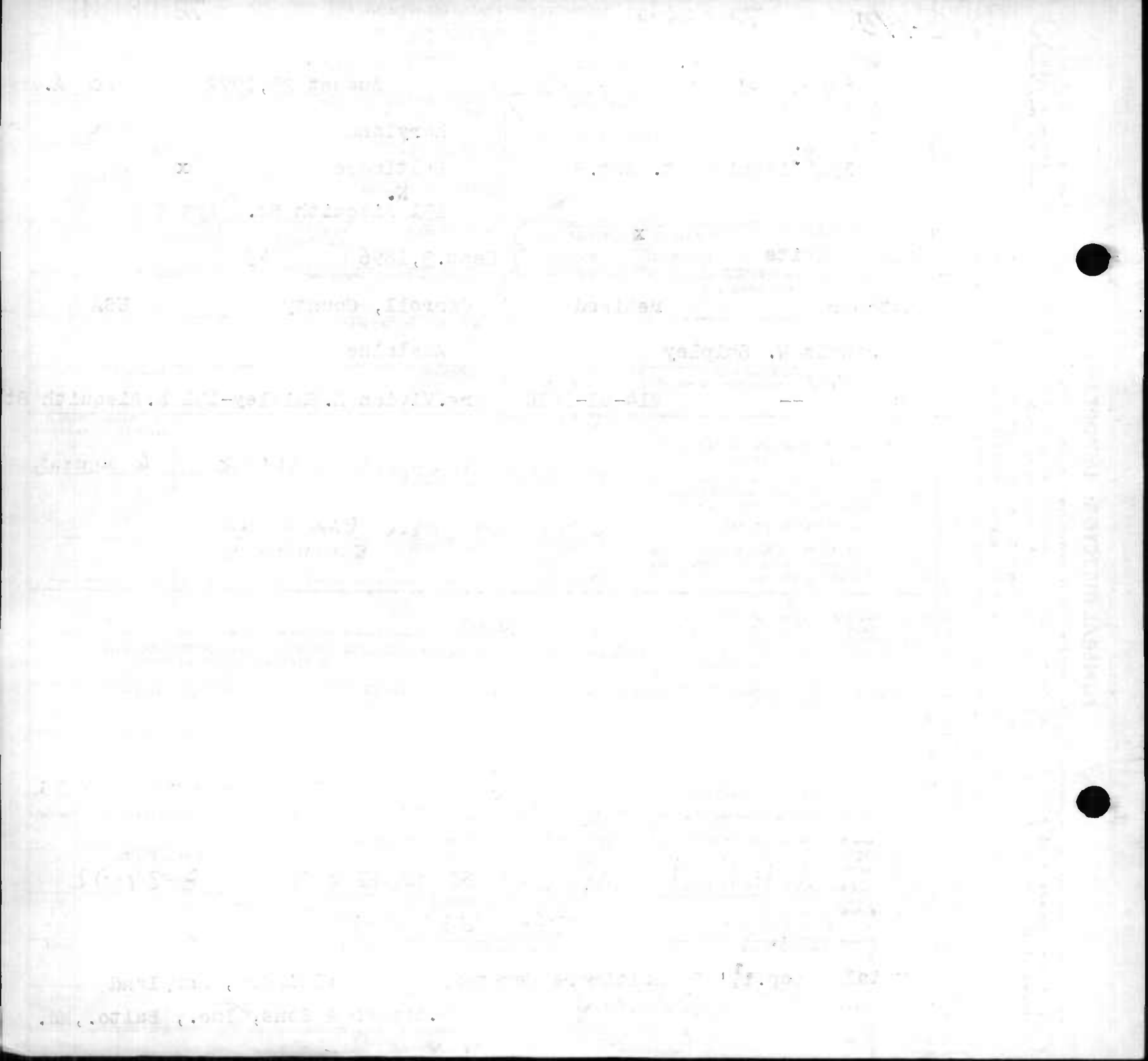


1992.4.5 | 5 | 4 | 26

FUNERAL DIRECTOR: IMPORTANT

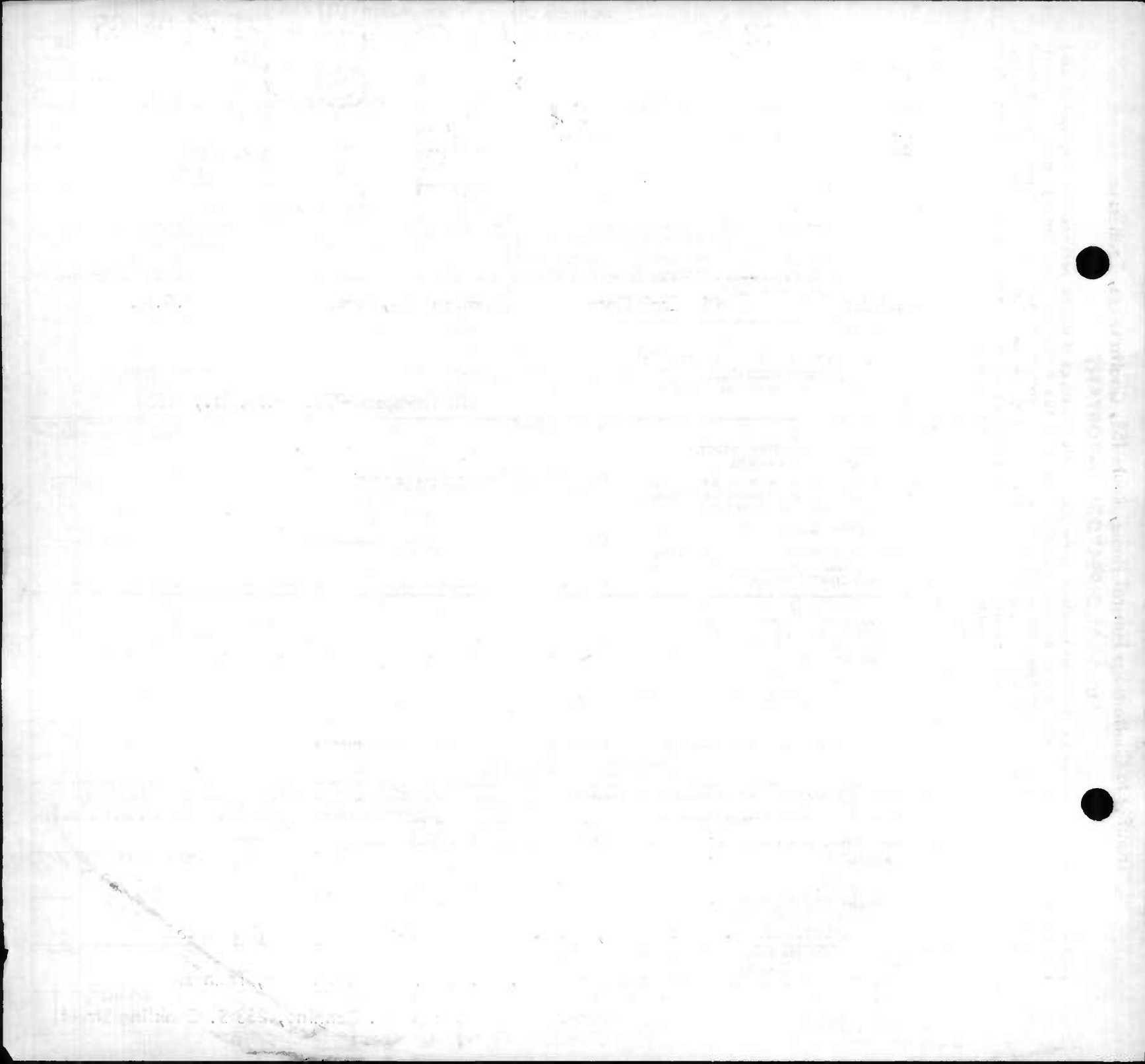
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 08364</u>
BIRTH NO. <u>S140</u>		STATE OF MARYLAND-DEME		
1. NAME OF DECEASED (Type or Print) <u>FRANCIS P. SHIPLEY</u>		2. DATE AND HOUR OF DEATH <u>August 29, 1972</u> <u>10</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>501</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>131 Aisquith St. Apt. 2 G</u>		
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		8. DATE OF BIRTH <u>Sept. 3, 1896</u> 9. AGE (In years last birthday) <u>75</u>
11. BIRTHPLACE (State or foreign country) <u>Carroll, County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Francis W. Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Adalaine</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-1410</u>		17. INFORMANT ADDRESS <u>Mrs. Vivian E. Shipley-131 N. Aisquith St</u>
18. <u>150X1</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>TERMINAL CANCER</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>SQUAMOUS CELL CARCINOMA</u>				
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ESOPHAGUS</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>NONE</u>				(C) _____
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> 19 <u>72</u> to <u>AUGUST</u> 19 <u>72</u>		that (I) (we) last saw the deceased alive on <u>Aug. 21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Richard M. Hunt M.D.</u>		23B. DATE SIGNED <u>8-29-72</u>		23C. PHYSICIAN'S NAME (Type) <u>RICHARD HUNT M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Sep. 1, '72</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE (State) <u>Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR <u>Sidney Johnston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H. Sander &amp; Sons, Inc., Balto., Md.</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08365		REG. NO. 72 08365	
T-512				72 08365			
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print) <u>Thompson Bernard T.</u>				2. DATE AND HOUR OF DEATH <u>8/29/72</u> <u>10 - P</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2652</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>31 Johns Hopkins Hospital</u>				C. CITY OR TOWN <u>BAITIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>5514 FRANK FORD AVE.</u>			
5. SEX <u>male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-09-12</u>	9. AGE (In years last birthday) <u>59</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Die Craft Corp</u>		11. BIRTHPLACE (State or foreign country) <u>Chattanooga, Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thompson James</u>				14. MOTHER'S MAIDEN NAME <u>Engle Minnie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Bill Thompson - 7759 Balto. St., 21224</u>			
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac - Deep Arrest</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary artery disease &amp; MI</u> <u>2 Years</u>			
				(B) DUE TO, OR AS A CONSEQUENCE OF: <u></u>			
				(C) DUE TO, OR AS A CONSEQUENCE OF: <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>8/29/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CAD &amp; MI</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/28</u> 19 <u>72</u> to <u>8/29</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/29</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <u>Michael R. Petracek M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/29/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael R. Petracek, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal to</u>		24B. DATE <u>9/2/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Chattanooga Mem. Pk. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Chattanooga, Tennessee</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR <u>Audrey Johnston</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Joseph N. Zannino, 263 S. Conkling Street</u>			



72 08366

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 08366  
STATE OF MARYLAND-DHMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY M. KURTIK

2. DATE AND HOUR OF DEATH

29 AUG 72, 7:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE City Hosp's.

4940 Eastern Avenue Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTO.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

4940 Eastern Avenue 21224

5. SEX

Female

6. RACE

Caucasian

7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

18 Mar. 1914

9. AGE (In years  
last birthday)

58

11. Under 1 Yr.  
Months Days12. Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME.

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

MICHAEL MATISZ

14. MOTHER'S MAIDEN NAME

MARY KRAYNICK

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH: RECORDS Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Sudden.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C) Diabetes Mellitus

1950

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Cerebrovascular Accident Likened 1961

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

O

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5 Jan 62 19 to 29 Aug 1972  
that (I) (we) last saw the deceased alive on 28 Aug 72 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Edmund Beacham M.D.

Attending  
Phys. ☐Med.  
Director ☒Staff  
Phys. ☐

23B. DATE SIGNED

29 Aug 72

23C. PHYSICIAN'S  
NAME (Type)

Edmund Beacham M.D.

23D. ADDRESS

DEGREE

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

9-1-72

24C. NAME OF CEMETERY or CREMATORY

HOLLY HILL MEMORIAL GARDENS. 2117 OLD OREMS RD, BALTO, CO., MD,

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 31 1972

25B. NAME OF REGISTRAR

Audrey H. Weston

25C. FUNERAL DIRECTOR

Charles G. Fisher 6224 EASTERN AVE.  
BALTO., 21224, MD.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REPORT 22  
PENNSYLVANIA  
MARY KAY

REPORT 22  
PENNSYLVANIA  
MARY KAY

REPORT 22



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08367

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES RANDALL

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

August 27, 1972

7:10 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Bon Secours Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

August 27, 1972

7:10 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

JUNE 18, 1948

10. AGE (In years  
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3421 Stollington Avenue

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

PRESTON L. RANDALL

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14b. KIND OF BUSINESS OR INDUSTRY

UNEMPLOYED

15. MOTHER'S MAIDEN NAME

NAOMI BUTLER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

214-50-6833

18. INFORMANT

ADDRESS

NAOMI RANDALL 5519 STONINGTON AVENUE

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of abdomen  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIBUTING  
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Park

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1300 W. Lexington Street

22D. TIME  
OF INJURY  
(APPROX.)

8-27-72

3:20 A. M.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot by unknown assailant

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 27, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

9-1-72

24C. NAME of CEMETERY or CREMATORY

ARBUTUS MEMORIAL PARK

24D. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

AUG 31 1972

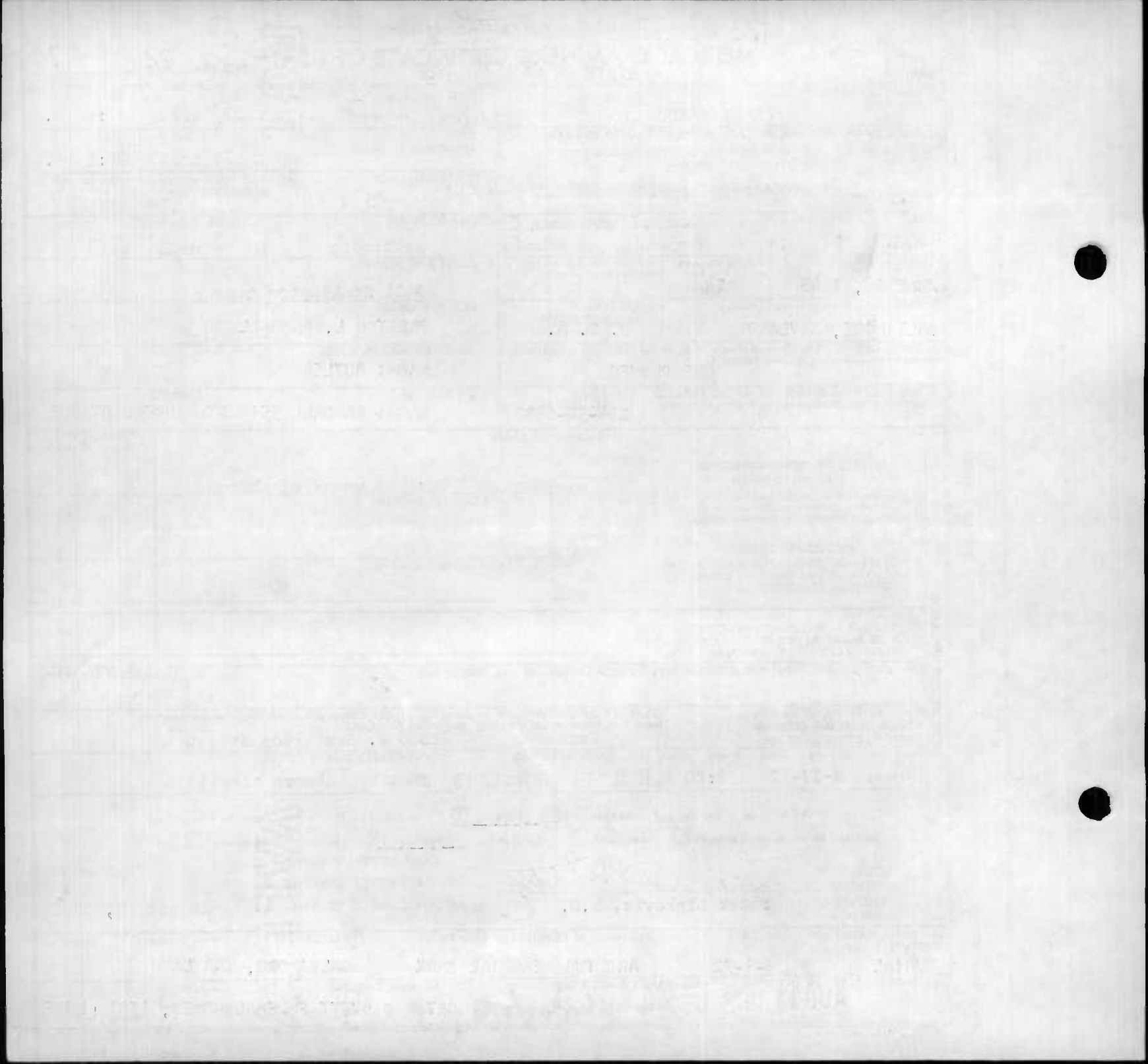
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MORTON &amp; DYETT FUNERAL HOMES, 1701 LAURENS

STREET



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08368

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Joseph Lee</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>7 24 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>7 24 72 8:25 a.</b> M.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6-5-29</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W.T. Lee</b>		14. MOTHER'S MAIDEN NAME <b>MARY A. Wilson</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocarditis and sepsis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) cervical abscess DUE TO, OR AS A CONSEQUENCE OF: (C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Marvin Platt, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>7/25/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-27-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Johnston</b>	
25C. FUNERAL DIRECTOR <b>Wesley Chaves Jr</b>		ADDRESS <b>1922 Edmondson</b>	

9-6-1972 - Letter from the Office of the Chief Medical Examiner, Marvin S. Platt, M.D.

Assistant Medical Examiner HRS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08369

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>James Logston (Logsdon)</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 30 72</b>		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Balto. City Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 30 72 12:15 a.</b>		M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2634</b>				
6. SEX <b>male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>
9. DATE OF BIRTH <b>6/30/41</b>		10. AGE (In years last birthday) <b>31</b>	E. STREET AND NUMBER <b>1026 Lerew Way</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>William L. Logsdon</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Rose Marie (Stakem)</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>215-40-4961</b>		18. INFORMANT <b>Mrs. Rose Marie Cheezum</b>
19. <b>E968X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Blunt trauma to abdomen</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Blunt trauma to abdomen</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>PARKING LOT</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1000 Blk. of Armstead Way</b>
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>8 22 72 11:15 p.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject was beaten.</b>
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type) DATE SIGNED <b>8/30/72</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>8/30/72</b>	24C. NAME of CEMETERY or CREMATORY <b>Security Process Inc.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md. 21228</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Heston</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. Balto., Md. 21214</b>

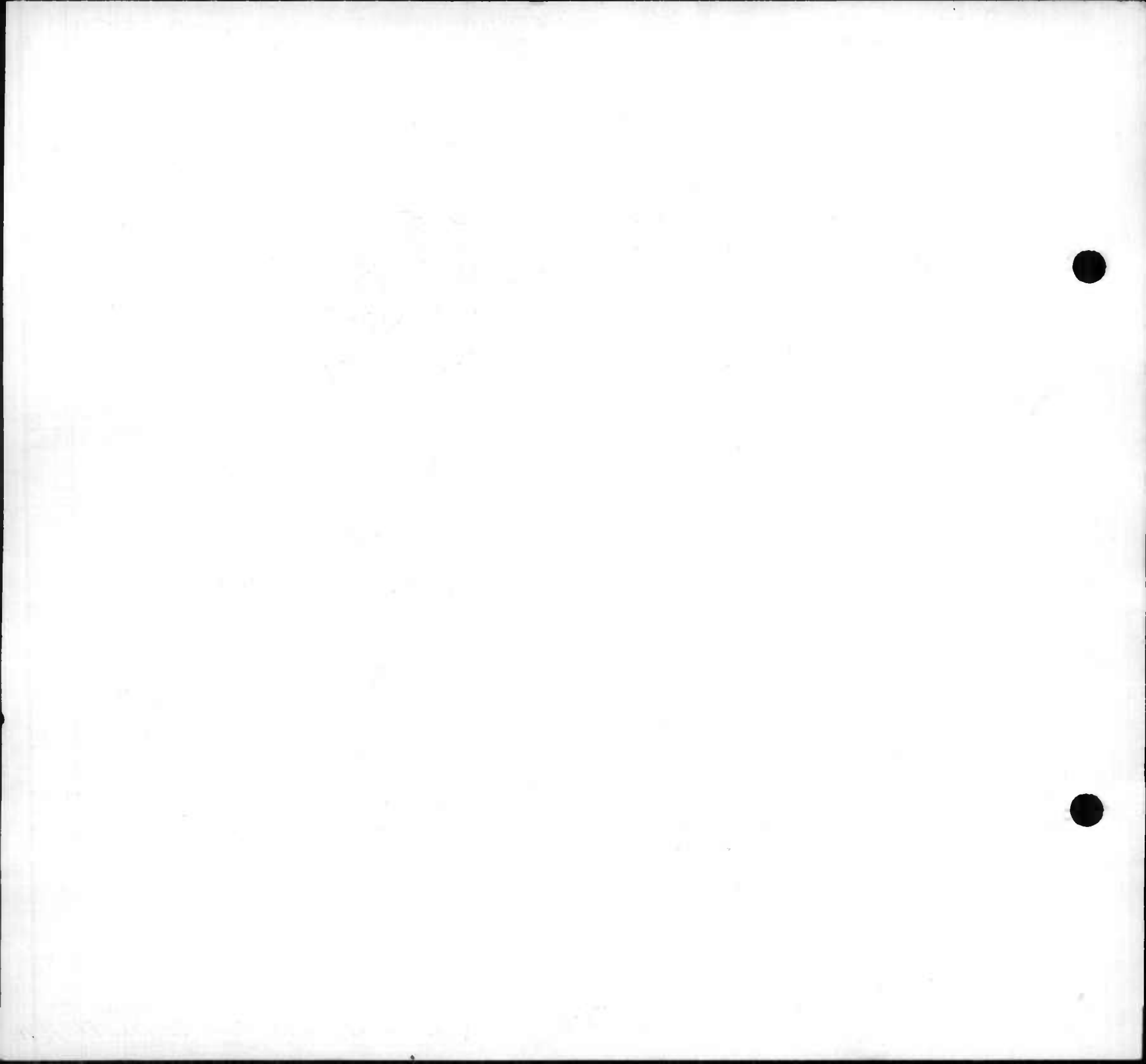




This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-160		72 08370		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08370	
BIRTH NO.				STATE OF MARYLAND-DMH			
1. NAME OF DECEASED (Type or Print) Edward Cooper				2. DATE AND HOUR OF DEATH 8/30/72 12-30 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1607 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2905 Winchester Street			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/30/1912	9. AGE (In years lost birthday) 60	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Joseph Cooper				12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-03-7095		17. INFORMANT Flossie H. Cooper 2905 Winchester	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: (B) cerebral vascular accident. DUE TO, OR AS A CONSEQUENCE OF: (C) chronic renal failure.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/3/72 19 to 8/30/72 1972 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gunders				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) E-SANDROU	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 9-5-72		24C. NAME OF CEMETERY or CREMATORY Bolto Cemetery	
24D. LOCATION Bolto Md.				25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972			
25B. NAME OF REGISTRAR A. S. H. H. H.				25C. FUNERAL DIRECTOR W. B. C. MARCH 928 E. NORTH AVE			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08371

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Eppie Chapman</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 30 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1626 Ashland Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 30 72 5:30 a.</b> M.	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>4-14-46</b>		10. AGE (In years last birthday) <b>26</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Eppie E. Chapman</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>704</b>	
15. MOTHER'S MAIDEN NAME <b>Mattie Stokes</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes Vietnam</b>	
17. SOCIAL SECURITY NO. <b>212-44-9869</b>		18. INFORMANT ADDRESS <b>Mattie Chapman 1626 Ashland Ave.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cirrhosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8/30/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-2-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel, Cty., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E North Ave.</b>	

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*Handwritten signature*

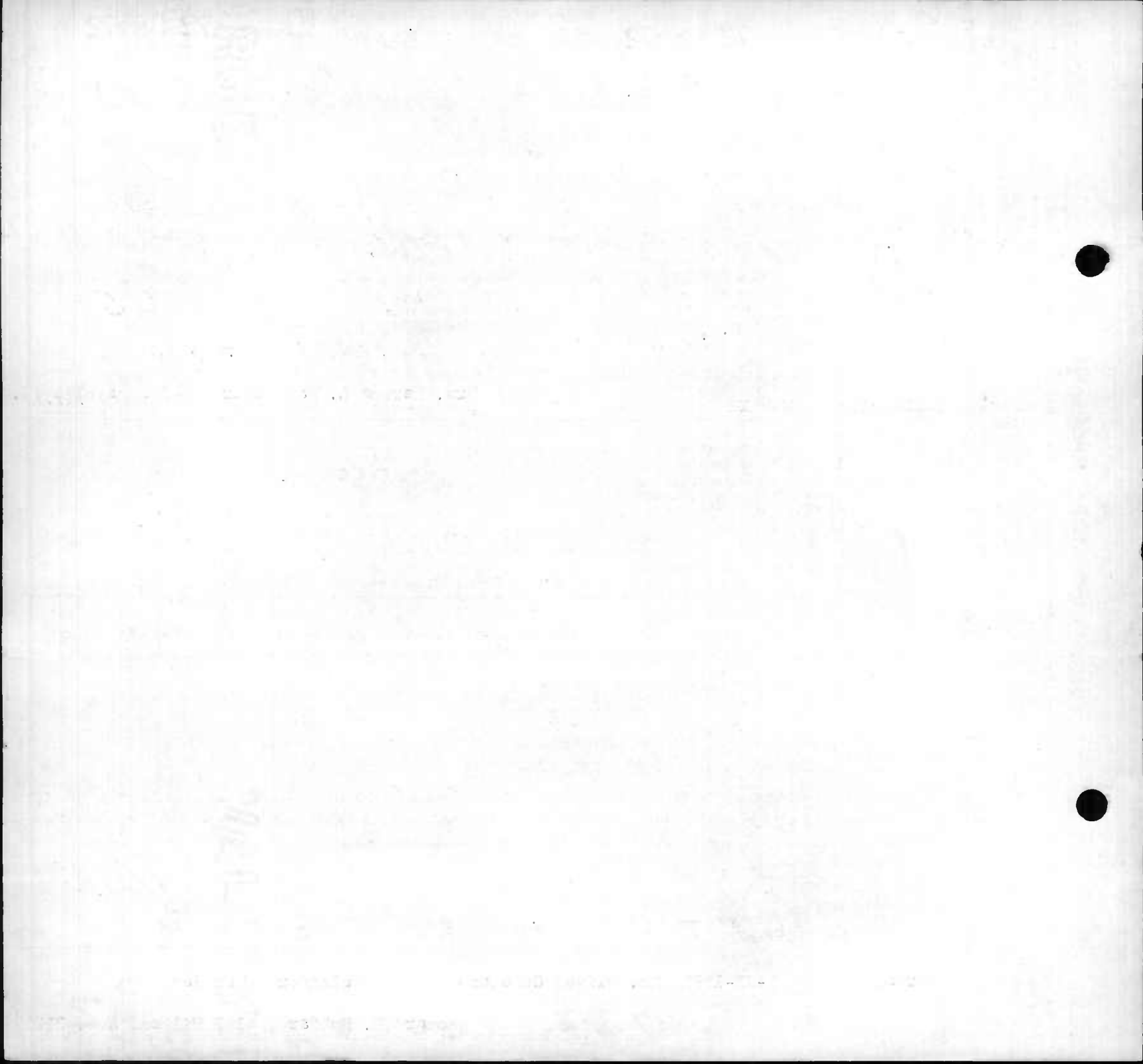
1944

1944

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

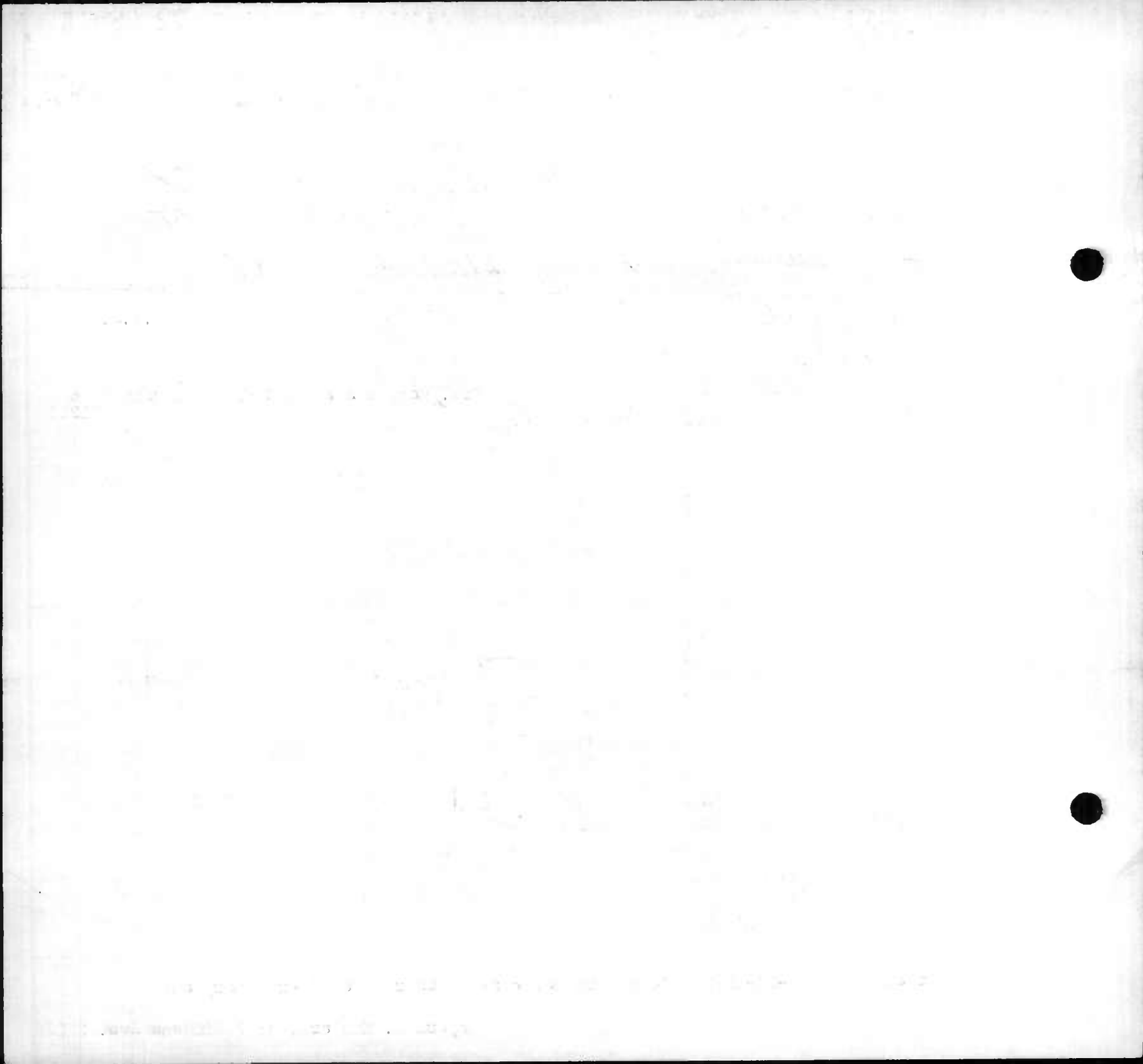
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08372</b>
72 08372				STATE OF MARYLAND-DECEASED
S-242 BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Lee R. Sheckell</b>		
2. DATE AND HOUR OF DEATH <b>8/28/72</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>South Baltimore General Hospital</b>		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1901</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hospital</b>		
6. CITY OR TOWN <b>Baltimore</b>		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. STREET AND NUMBER <b>127 S. Fulton Ave</b>				
9. SEX <b>M</b>	10. RACE <b>W</b>	11. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12. DATE OF BIRTH <b>11/6/21</b>	13. AGE (In years last birthday) <b>50</b>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paper Cutter</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Realart Press Inc.</b>		16. BIRTHPLACE (State or foreign country) <b>MD.</b>
17. FATHER'S NAME <b>William Sheckells</b>		18. MOTHER'S MAIDEN NAME <b>Helen Kaufman</b>		
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>XXXXXXXXXX W W II</b>		20. SOCIAL SECURITY NO. <b>215-14-9717</b>		21. INFORMANT <b>Mrs. Bertha L. Dankmeyer, 3805 Annapolis Rd. 21227</b>
22. I certify that (I) (this hospital) attended the deceased from <b>August 3, 1972</b> to <b>August 28, 1972</b> that (I) (we) last saw the deceased alive on <b>August 28, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <b>Stanford J. Huber MD</b>		
24. DATE SIGNED <b>8/28/72</b>		25. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		
26. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		27. ADDRESS <b>4107 Wilkens Ave. 21229</b>		
28. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		29. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
30. DATE OF OPERATION <b>3 8/14</b>		31. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer @ lung</b>		
32. AUTOPSY? (Yes or No) <b>Yes</b>		33. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
34. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		35. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Chronic obstructive pulmonary disease many years</b>		
36. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>(Month) (Day) (Year) (Hour)</b>		37. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
38. HOW DID INJURY OCCUR?				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08373	
CERTIFICATE OF DEATH				REG. NO. 72 08373	
STATE OF MARYLAND-DEMD					
BIRTH NO. <b>L-521</b>		72 08373			
1. NAME OF DECEASED (Type or Print) <b>LAURA E. LANGFORD</b>		2. DATE AND HOUR OF DEATH <b>8/28/72</b> <b>8:25 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH Charles GEN Hosp</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2724 N. Charles ST.</b>		A. STATE <b>Md.</b> B. COUNTY <b>1902</b>	
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>1338 W. Hollins ST.</b>					
5. SEX <b>F</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/12/04</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Alexander Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Mary McINTYRE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-12-3689</b>		17. INFORMANT <b>Mrs. Nadyne Stauch, 201 Athol Gate Lane, Hosp. Chart 21229</b>	
18. <b>25071</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>acute myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>atherosclerosis, coronary arteriosclerosis, etc.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Diabetes</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Stroke @ vasectomy without restrictions</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2-1-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-12-72</b> 19 to <b>8-28-72</b> 19 that (I) (we) last saw the deceased alive on <b>8-28-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. K. HILAK</b>		23B. DATE SIGNED <b>8-28-72</b>		23C. PHYSICIAN'S NAME (Type) <b>S. K. HILAK</b>	
23D. ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-31-1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Andrew J. H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>	
25D. ADDRESS <b>4107 Wilkens Ave. 21229</b>					

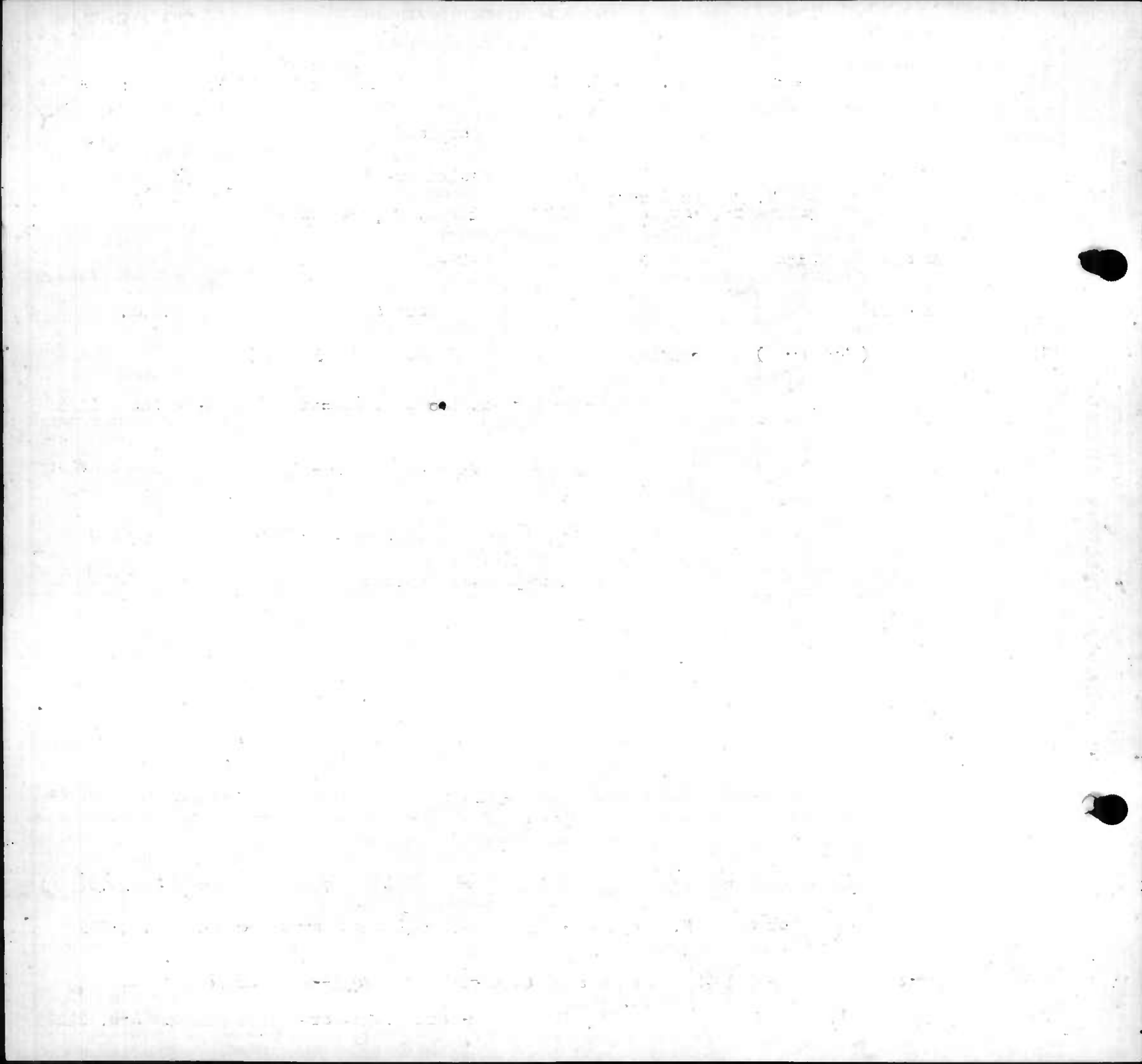




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 08374</span>	
A-626 <span style="font-size: 1.2em;">72 08374</span>				STATE OF MARYLAND-DEPT	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MARY</span>		<span style="font-size: 1.2em;">A. ARCHER</span>		August 28, 1972 <span style="float: right;">9:00 A</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.2em;">116 S. Gilmore Street Baltimore, Maryland 21223</span>				A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1903</span>	
				C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.2em;">116 S. Gilmore Street</span>	
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9-29-1890</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">81</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
				12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">( Unknown ) Shipley</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Agnes ( Unknown )</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220-07-0338</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Lewis H. Archer, 9615 Orpin Road 21133</span>	
18. <span style="font-size: 1.2em;">412.21</span> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Coronary arrest</span> <span style="float: right;">immediate</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <span style="font-size: 1.2em;">Hypertensive Cardio Vascular Disease</span> <span style="float: right;">25 yrs</span>	
				(C) <span style="font-size: 1.2em;">Atherosclerosis</span> <span style="float: right;">25 yrs</span>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">April</span> 1972 to <span style="font-size: 1.2em;">August</span> 1972, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">10 August</span> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Herman H. Baylus MD</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">29 August 72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Herman H. Baylus</span>				23D. ADDRESS <span style="font-size: 1.2em;">1600 Wilkens Avenue, Balto., Md. 21223</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">8-31-1972</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Union Chapel Cemetery</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Fallston, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">AUG 31 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Sidney H. Hubbert</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Howard H. Hubbard, 4107 Wilkens Ave. 21229</span>	



B-526

72 08275

BALTIMORE CITY HEALTH DEPARTMENT

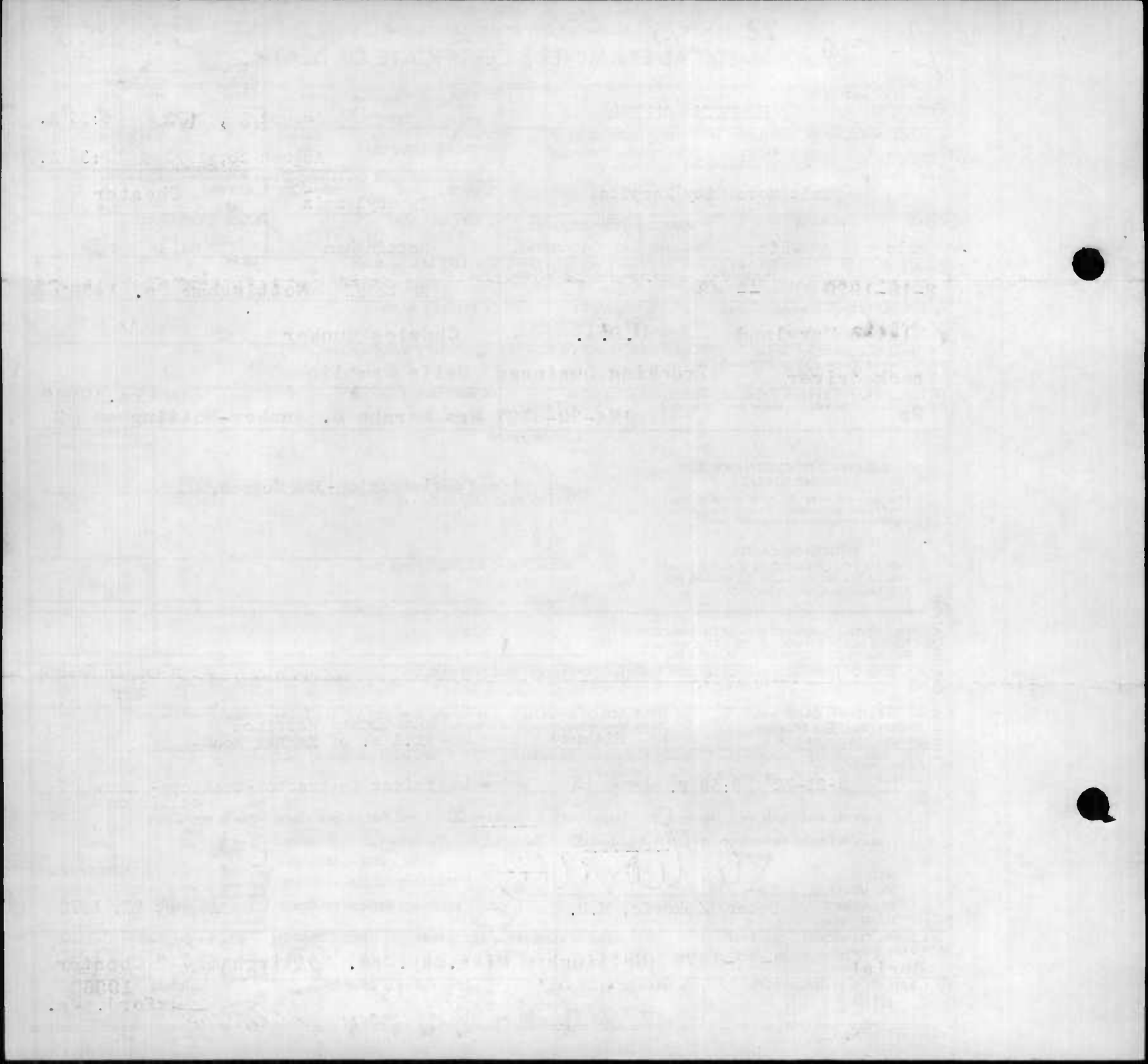
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08275

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		KENNETH BUNKER		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour	
								August 26, 1972		8:35 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month Day Year		Hour			
Baltimore City Hospital								August 26, 1972		8:35 A.M.	
6. SEX				7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)			
Male		White						A. STATE		B. COUNTY	
								Pennsylvania		Chester	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
2-18-1929		44 43		Elkton Maryland		U.S.A.		Charles Bunker		Delia Hamblin	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME			
Truck driver				Trucking Business				Delia Hamblin			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.				18. INFORMANT			
No				194-22-8727				Mrs Marsha H. Bunker-Nottingham #2			
19. CAUSE OF DEATH				20. DATE OF OPERATION				21. AUTOPSY? (Yes or No)			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH								Yes			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE				Conflagration-3rd degree, 60%			
				DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B)				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.											
II				(C)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
				Highway				Harrison Rt. 1 s. of HUNTER Road			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED				22F. HOW DID INJURY OCCUR?			
8-21-72 9:58 P. m.				WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				Driver in tractor-trailer - auto collision			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER							
Peter Lipkovic, M.D.				ASSOCIATE MEDICAL EXAMINER				August 27, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)		Pa	
Burial		8-29-1972		Nottingham Miss. Bap. Cem.		Nottingham # 2		Chester			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS		19363		Oxford, Pa.	
AUG 31 1972		Andrew S. Boston		William G. Johnston							



## CERTIFICATE OF DEATH

REG. NO. 72 08276  
STATE OF MARYLAND

BIRTH NO. L-516

1. NAME OF DECEASED  
(Type or Print)

LAMBERT, MAURICE Delbert

2. DATE AND HOUR OF DEATH

August 29 - 1972 7:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

MARYLAND 2747

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2922 SYLVAN AVE

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

1-24-15

9. AGE (In years  
last birthday)

57

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Disabled - Printer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Leo M. Lambert

14. MOTHER'S MAIDEN NAME

Annie E. Lambert

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)  
No

None

16. SOCIAL SECURITY NO.

216-07-9686

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH Records Baltimore, Maryland 21224

18.

340X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Septicemia

(B) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

URINARY tract infection

(C) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Multiple sclerosis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Prob. last 2 days

Prob. last 4 days

Prob. + than 20 years

Last 3 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Pressure SORES.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 8 1970 to August 29 1972  
that (I) (we) last saw the deceased alive on August 29 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Arturo J. Salazar M.D.

DEGREE

Attending ☐Med. ☐Staff ☒

23B. DATE SIGNED

August 29-72

23C. PHYSICIAN'S  
NAME (Type)

ARTURO J. SALAZAR M.D.

DEGREE

23D. ADDRESS

4940 Eastern Avenue  
Baltimore City Hospitals Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

9/2/1972

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county) (State)  
Baltimore Parkville 21234 Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 31 1972

25B. NAME OF REGISTRAR

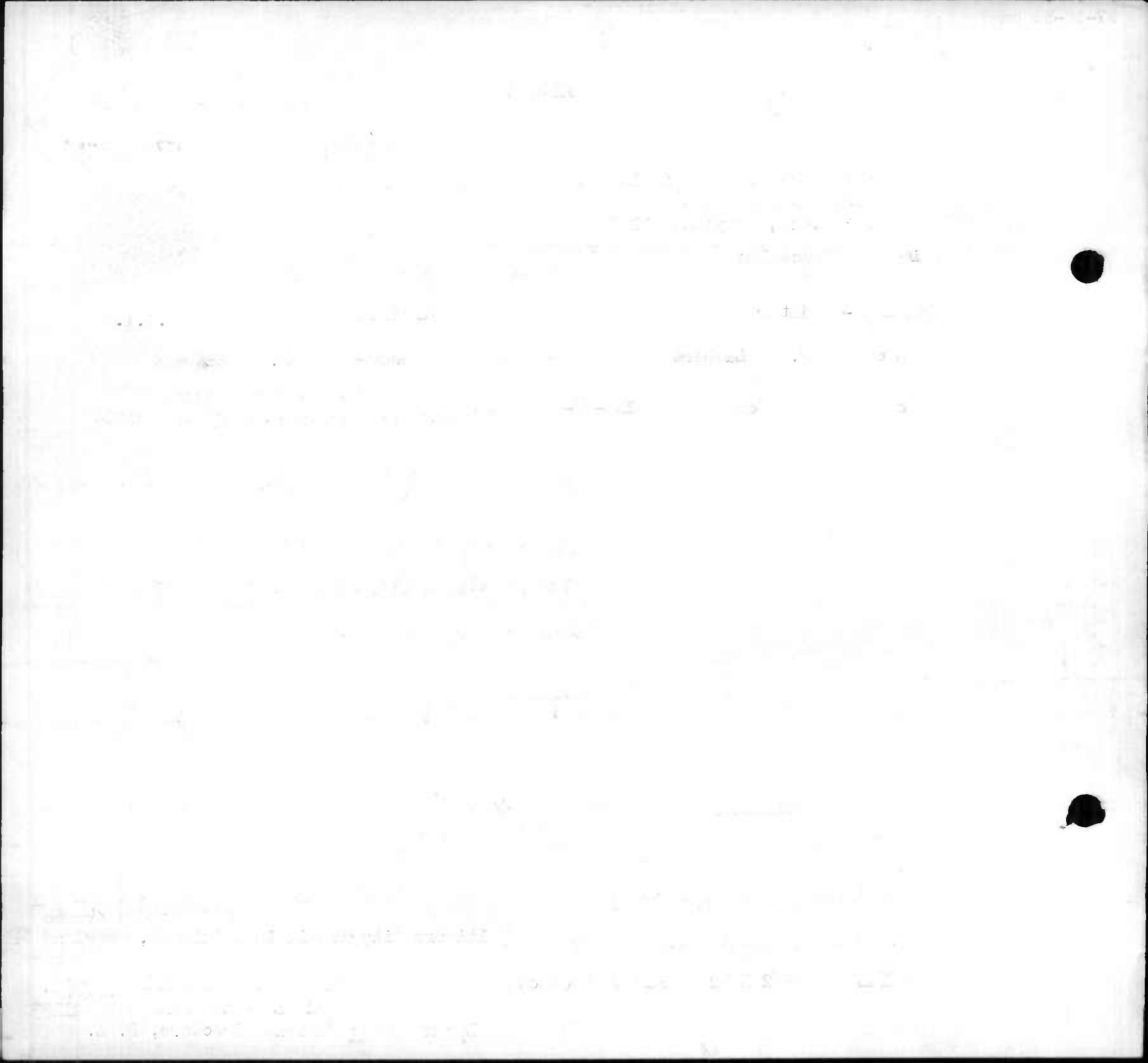
Sidney H. Hinton

25C. FUNERAL DIRECTOR 8728 Liberty Road ADDRESS 21133

Loring Byers Funeral Directors, P. A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARGUERITE A. HAYNIE</b> <b>MARGRET HAYNIE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 8-25 or 8-26 1972		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>205 East 30th Street, Apt. 2</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 26, 1972</b>		Hour M. <b>6:30 A.</b>	
6. SEX <b>Female</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>MAY 6, 1928</b>		10. AGE (In years last birthday) <b>44</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>	
12. CITIZEN OF <b>USA</b>		13. FATHER'S NAME <b>MR. WARREN H. HAYNIE, SR.</b>		14. MOTHER'S MAIDEN NAME <b>AGNES M. ROWLEY</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERICAL</b>		16. KIND OF BUSINESS OR INDUSTRY <b>H.V. NURSING HOME</b>		17. SOCIAL SECURITY NO. <b>217-24-4192</b>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		19. INFORMANT <b>MR. W.H. HAYNIE, JR.</b>		20. ADDRESS <b>BRO.)</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>8/29/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type): CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>August 26, 1972</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/29/72</b>		24C. NAME of CEMETERY or CREMATORY <b>NEW CATHEDRAL CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD HOME</b>		25D. ADDRESS <b>6500 York Rd. 21212</b>			

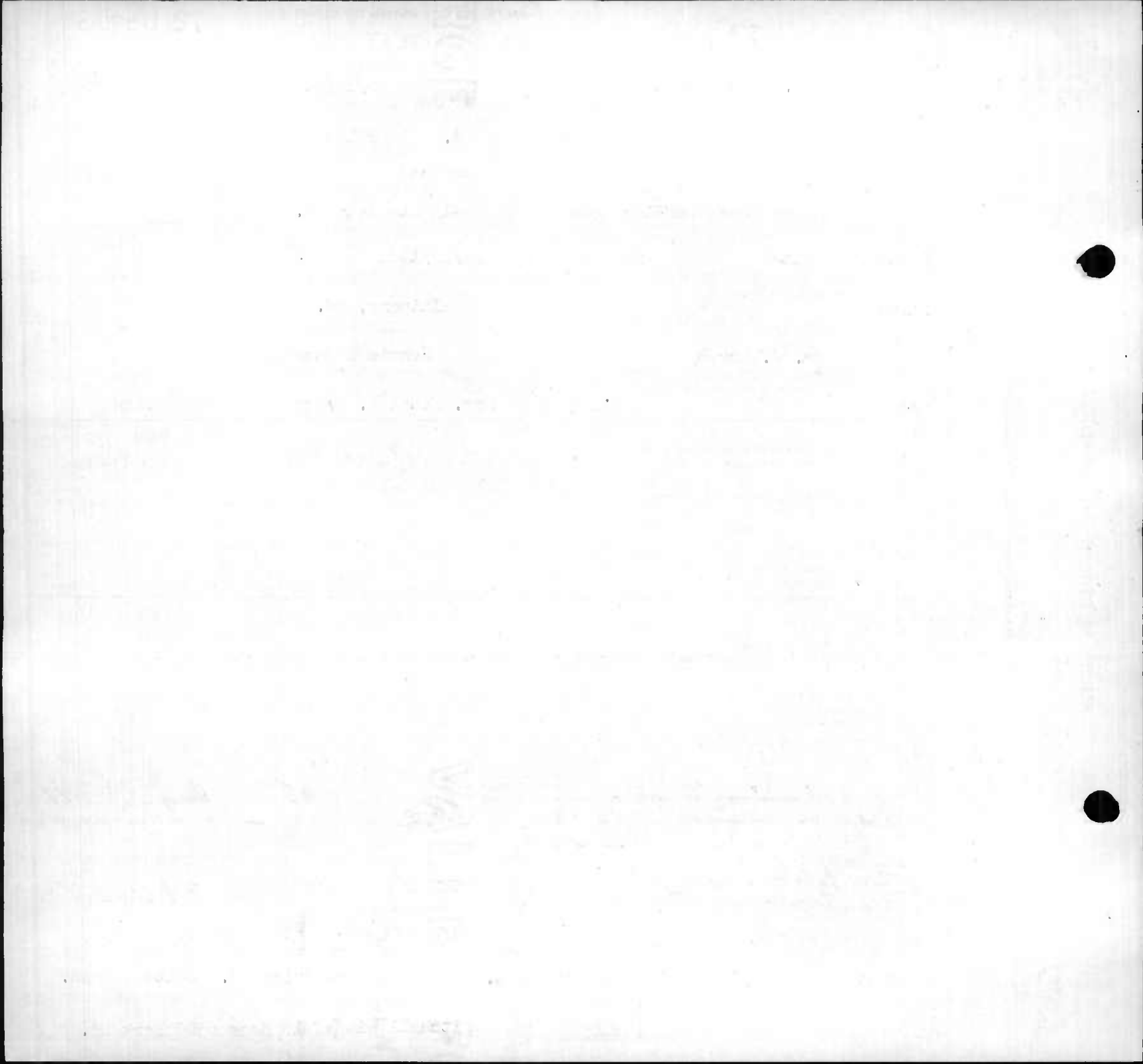


THE STATE OF TEXAS,  
COUNTY OF DALLAS.I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Dallas, Texas.GIVEN UNDER MY HAND AND SEAL OF OFFICE, this 1st day of January, 1900.CLERK OF COUNTY.JAN 1 1900

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08278		72 08278	
K-540				72 08278		72 08278	
BIRTH NO.				72 08278		72 08278	
1. NAME OF DECEASED (Type or Print) <b>F. Edith Knell</b>				2. DATE AND HOUR OF DEATH <b>8/28/72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>Long Green Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN <b>Gaywood</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>6415 Blenheim Rd.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/1881</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		
13. FATHER'S NAME <b>Wm. J. Murphy</b>			14. MOTHER'S MAIDEN NAME <b>Jennie L. Gosnell</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>217222952 D</b>		17. INFORMANT <b>Mrs. Mabel L. Reese</b>		ADDRESS <b>Same</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Or cancer of esophagus</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>16 Aug.</b> 19 <b>72</b> to <b>29 Aug.</b> 19 <b>72</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>16 Aug.</b> 19 <b>72</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> (did not) view the body after death.							
23A. SIGNATURE <b>William H. Kammer, Jr.</b> DEGREE						23B. DATE SIGNED <b>29 Aug. 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM H. KAMMER, JR. M.D.</b> DEGREE						23D. ADDRESS <b>6011 YORK RD. BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/30/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemt.</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Rd. Balto Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Lidney Wiedefeld</b>		25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld</b>		ADDRESS <b>Home 6500 York Rd.</b>	



72 08279

STATE OF MARYLAND-DEPT.  
BALTIMORE CITY HEALTH DEPARTMENT

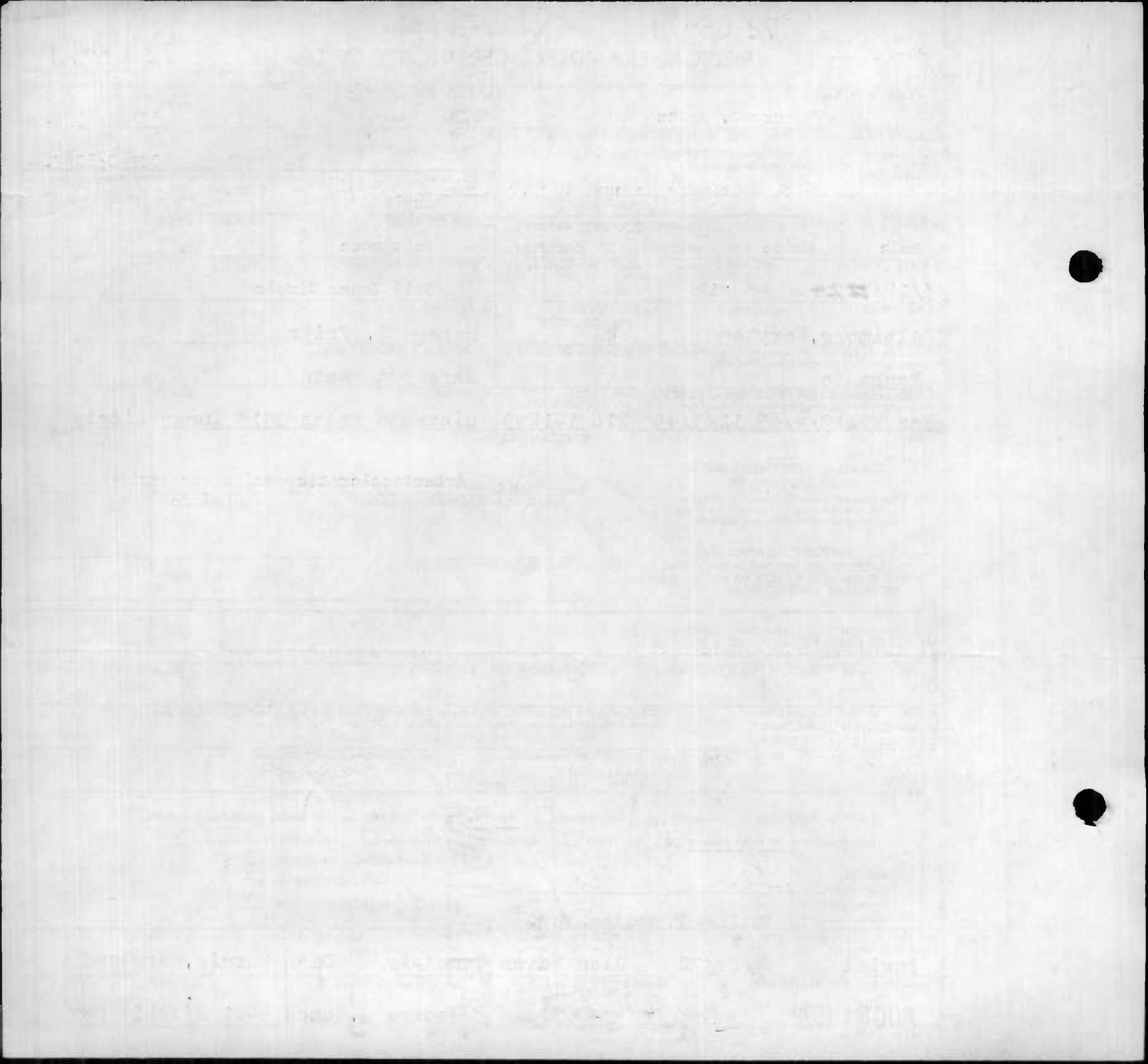
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08279

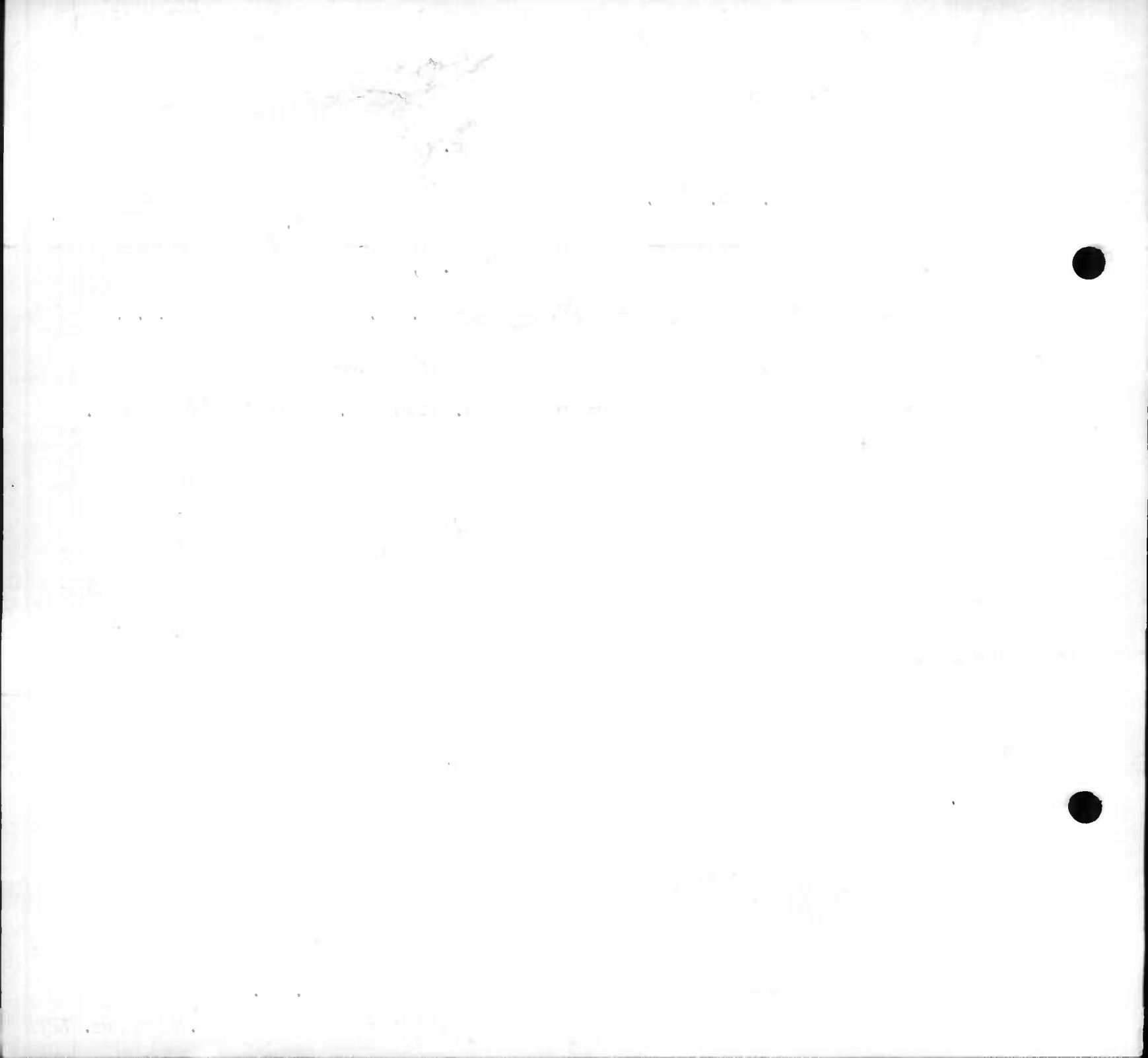
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Harry G. Fritz</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 8 24 72 3:53 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hosp.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 8 24 72 3:53 P. M.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		15. MOTHER'S MAIDEN NAME <b>Margaret Reth</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW2 3/4/43 12/3/45</b>		17. SOCIAL SECURITY NO. <b>218 141293</b>	
18. INFORMANT <b>Giovanna Fritz</b>		ADDRESS <b>391.9 Inner Circle</b>	
19. CAUSE OF DEATH <b>I</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>8/28/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>Yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William P. Mulloy, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/28/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Blen Burnie, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>George J. Gonce</b>	
25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		72 08380		BALTIMORE CITY HEALTH DEPARTMENT		72 08380	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.		STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <i>Bernice Mary Beall</i>		2. DATE AND HOUR OF DEATH <i>8-29-72</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>43 South Balto. Gen. Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2301</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Balto. Gen. Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 4, 1932</i>	
9. AGE (In years last birthday) <i>40</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine operator</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward Finger</i>		14. MOTHER'S MAIDEN NAME <i>Marie Kress</i>		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-28-6058</i>	
17. INFORMANT <i>Mr. William E. Beall</i>		ADDRESS <i>1402 Clarkson St.</i>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Respiratory insufficiency</i> <i>Metastatic Carcinoma extensive</i> <i>Carcinoma Left Breast</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
19A. DATE OF OPERATION <i>9-2-72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>George G. Finney Jr. MD</i>	
23B. DATE SIGNED <i>8/31/72</i>		23C. PHYSICIAN'S NAME (Type) <i>GEORGE G. FINNEY JR. MD</i>		23D. ADDRESS <i>3820 York Rd. Baltimore Md 21212</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	
24B. DATE <i>9-2-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>AUG 31 1972</i>	
25B. NAME OF REGISTRAR <i>Ashley Johnson</i>		25C. FUNERAL DIRECTOR <i>McCutty Funeral Homes</i>		ADDRESS <i>130 E. Fort Ave. 21230</i>		VS 150-REV. 1/1/68	

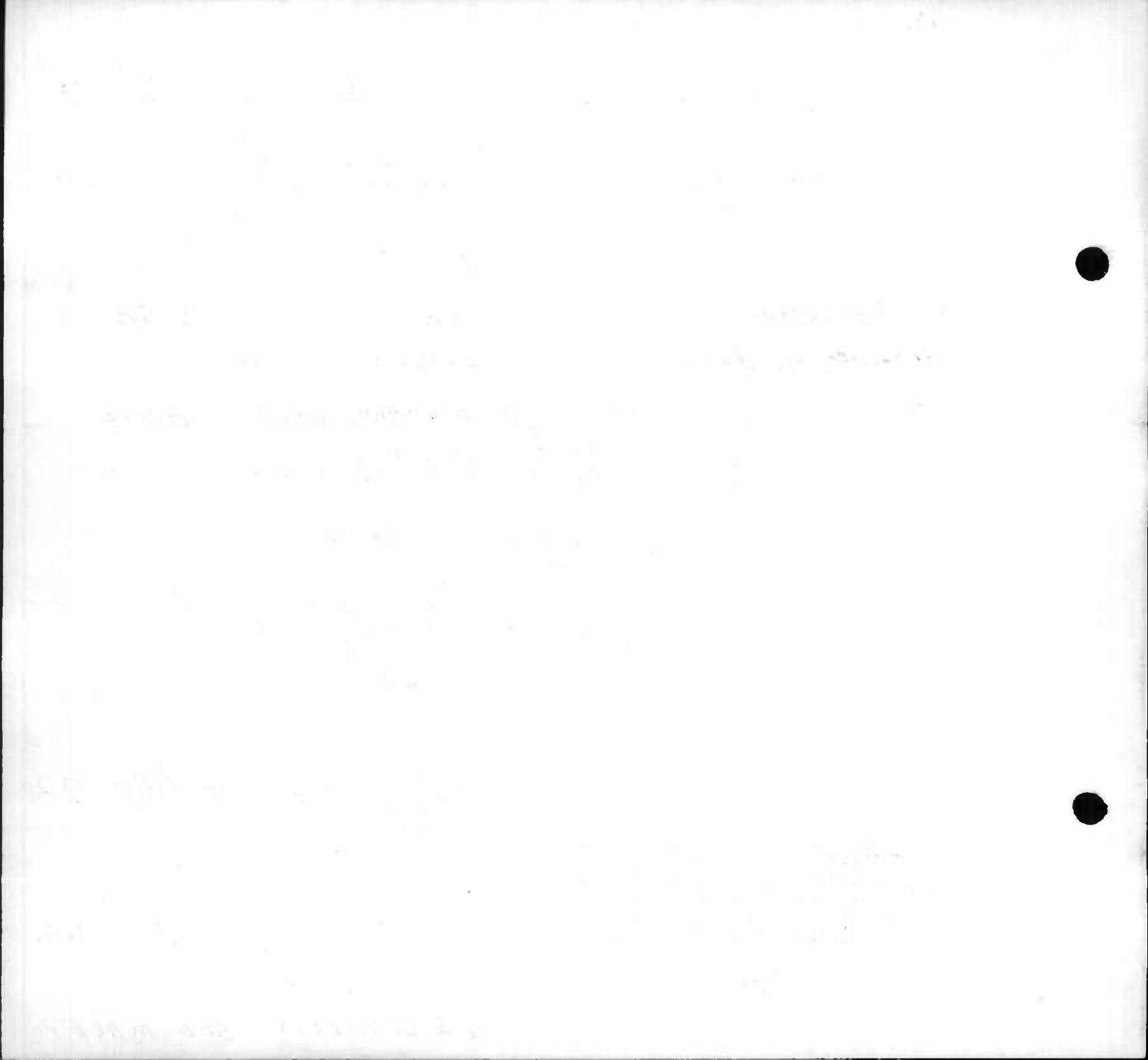




FUNERAL DIRECTOR: IMPORTANT

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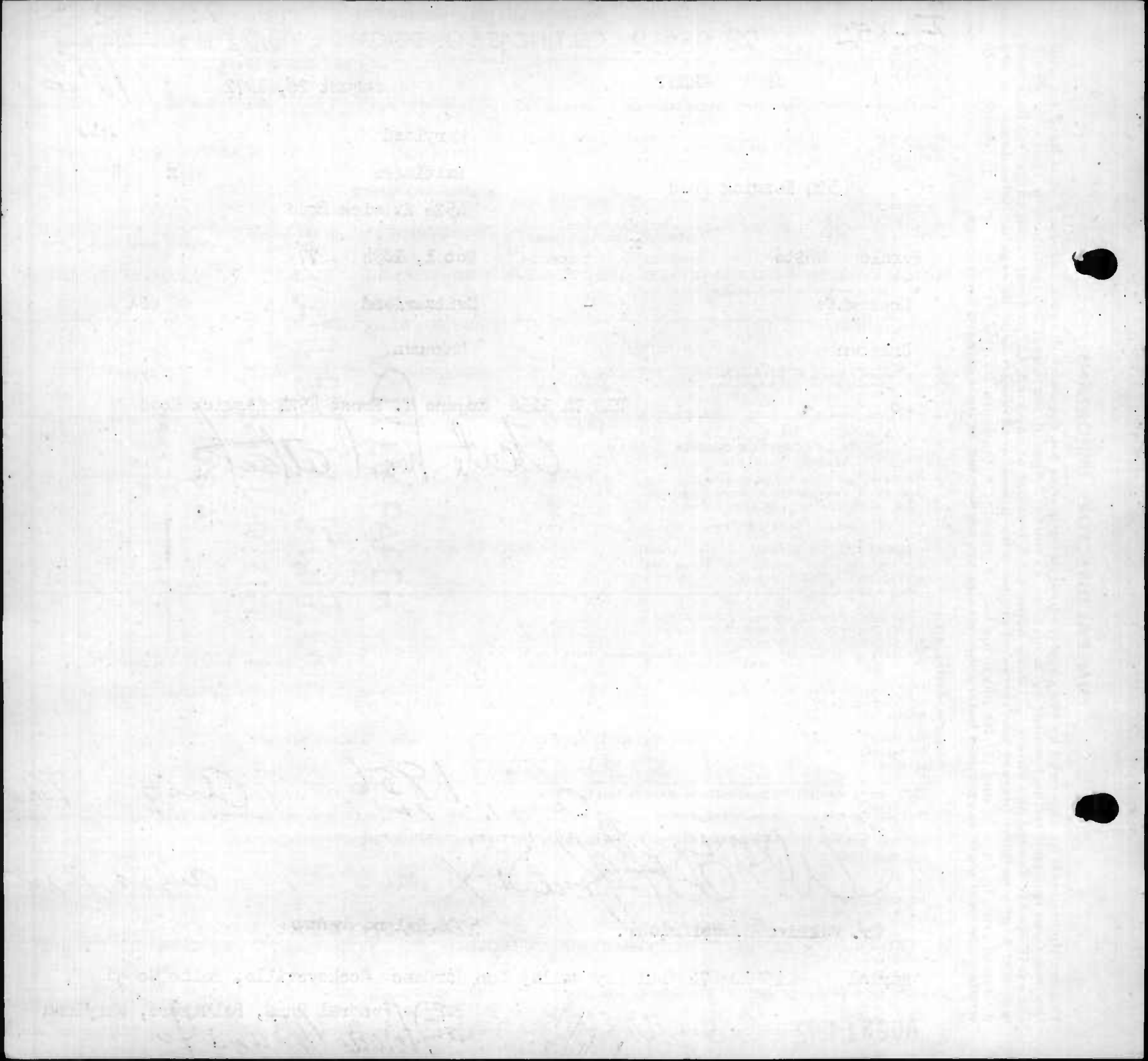
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08381	
W-300 72 08381		STATE OF MARYLAND-DEMD	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)	
		WOOD, HUNDLEY L.	
2. DATE AND HOUR OF DEATH		8/29/72 1330 P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
EDGEWOOD NURSING HOME		MD. BALTO	
90		C. CITY OR TOWN (BOWLEY'S QUARD, INSIDE CITY LIMITS?)	
		BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		E. STREET AND NUMBER	
M	6. RACE	BOX 643 RT 15	
W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		
	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH	
WAREHOUSEMAN		2-10-95	
10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
		77	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
VA.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
WILLIAM T. WOOD		LELLA DILLARD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		218-03-1823	
17. INFORMANT		ADDRESS	
RICHARD WOOD		ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)		14 R.	
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		14 R.	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		ASCVD. - Emphysema	
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from		21F. HOW DID INJURY OCCUR?	
that (I) (we) last saw the deceased alive on			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Anthony F. Carozza		8/29/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
ANTHONY F. CAROZZA		3217 YORK Rd BALD MD 21212	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
BURIAL		9/1/72	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
GARDENS OF FAITH		BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
AUG 31 1972		J. E. CONNELLY	
25C. FUNERAL DIRECTOR		ADDRESS	
J. E. CONNELLY		300 MACE	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-652		72 08382		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08382	
BIRTH NO.				STATE OF MARYLAND			
1. NAME OF DECEASED (Type or Print) ANNA ERNST				2. DATE AND HOUR OF DEATH August 26, 1972 12:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 4524 Keswick Road				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4524 Keswick Road			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 1, 1894	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 74 3156		17. INFORMANT ADDRESS Eugene T. Ernst 4524 Keswick Road			
18. 429.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ACUTE HEART ATTACK CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug 1, 1956 to Aug 19, 72 that (I) (we) (us) saw the deceased alive on Aug 1, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. William G. Helfrich				23B. DATE SIGNED Aug 29, 1972		23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich	
24A. BURIAL CREMATION Burial		24B. DATE 29 Aug 72		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem Gardens		24D. LOCATION (City, town, or county) (State) Cockeysville, Balto Co Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR Arling B. B. B.		25C. FUNERAL DIRECTOR Burgee Funeral Home, Baltimore, Maryland		25D. ADDRESS Burgee Funeral Home, Baltimore, Maryland	



K-523

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08383

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Charles Knight</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>8</b> Day <b>29</b> Year <b>72</b>		Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>29</b> Year <b>72</b>		Hour <b>9:55 a.</b>
6. SEX <b>male</b>		7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH <b>5-18-32</b>		10. AGE (In years last birthday) <b>40</b>		11. BIRTHPLACE (State or foreign country) <b>Phila., Pa.</b>
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>unk.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>
15. MOTHER'S MAIDEN NAME <b>Emmeline Scott</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.
18. INFORMANT <b>Mrs. Sadie Mae Knight</b>		19. ADDRESS <b>5512 Cadillac Ave. 21207</b>		

19. <b>E 8901</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Carbon monoxide &amp; soot inhalation</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Acute alcoholic intoxication</b>				
20A. DATE OF OPERATION <b>9-2-1972</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOUSE</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>5512 Cadillac Avenue</b>
22D. TIME OF INJURY (APPROX.) Month <b>8</b> Day <b>29</b> Year <b>72</b> Hour <b>9:13 a.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject in house fire.</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/30/72</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-2-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. FUNDRAISING DIRECTOR <b>1735 Harford Ave. 21213</b>		24F. FUNDRAISING DIRECTOR <b>Marshall W. Jones, Jr.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Adrian W. Jones</b>		25C. FUNDRAISING DIRECTOR <b>1735 Harford Ave. 21213</b>

72 08283 STATE OF MARYLAND-DIST

[Faint, mostly illegible text covering the main body of the document, possibly a form or report.]

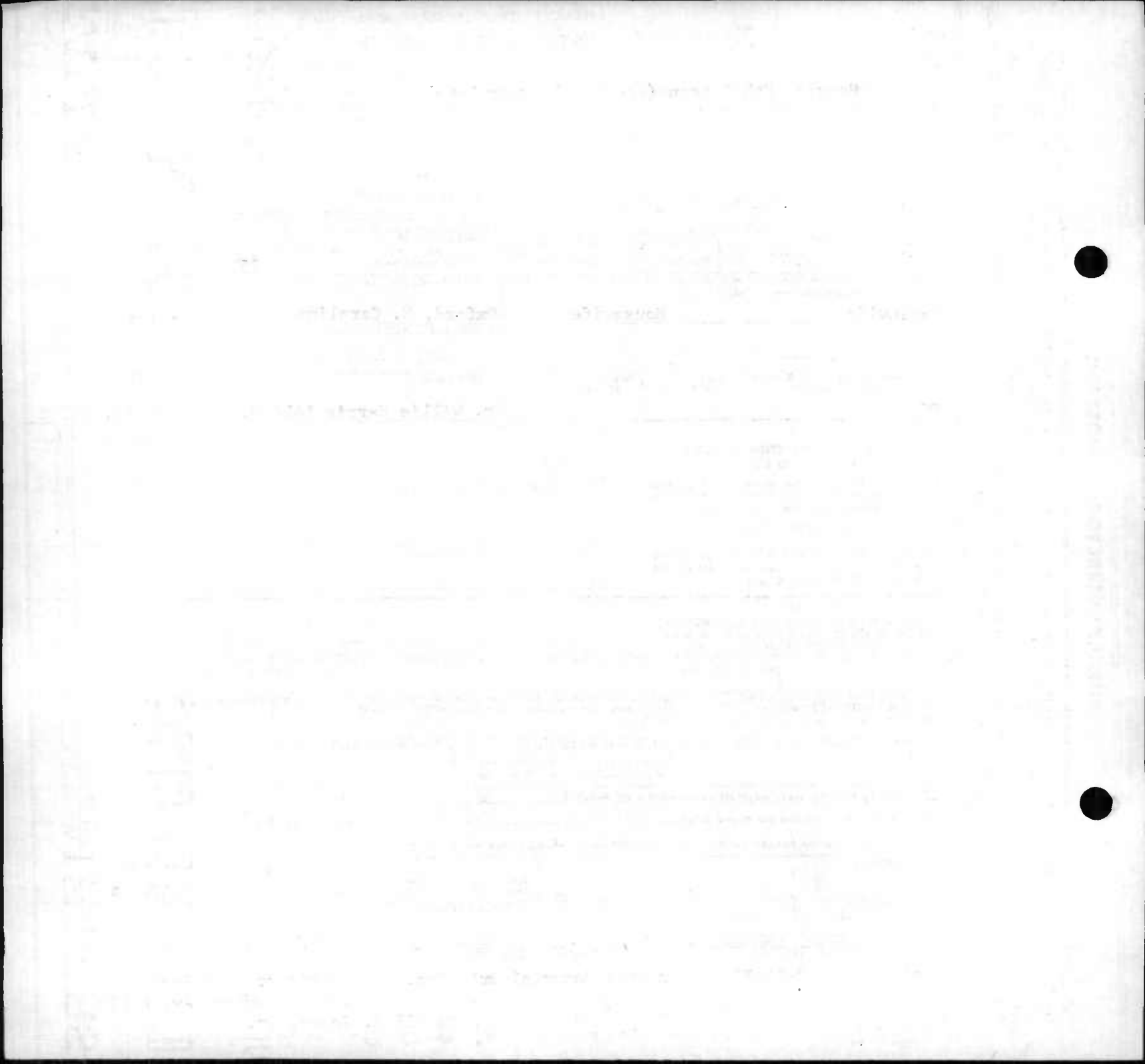


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08284</u>	
4-620 72 08284				CERTIFICATE OF DEATH	
BIRTH NO. <u>4-620</u>		1. NAME OF DECEASED (Type or Print) <u>Harris, Ethel Lean (Ethelean) Ether Lane</u>		2. DATE AND HOUR OF DEATH <u>August 28, 1972</u> <u>5:00 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE <u>Maryland</u> B. COUNTY <u>909</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Johns Hopkins Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1416 Asquith Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/16</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Oxford, N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Curtis Will</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clemmons</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Willie Harris 1416 N. Aisquith St. 21202</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>200.0 I</u> <u>Disease of condition directly leading to death</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Severe platelet depression and cerebral bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Reticulum cell sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 months</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Aug 8, 1972</u> to <u>Aug 28, 1972</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Aug 28, 1972</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Edward James Busick Jr.</u>				23B. DATE SIGNED <u>8/28/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Edward James Busick, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-31-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park, Inc.</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. FUNERAL DIRECTOR <u>1735 Hartford Av. 21215</u> <u>Marshall W. Jones, Jr.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR <u>Andrew J. [Signature]</u>		25C. FUNERAL DIRECTOR <u>1735 Hartford Av. 21215</u> <u>Marshall W. Jones, Jr.</u>	





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M-420-S-412  
M-242

72 08385

STATE OF MARYLAND - DEPT  
BALTIMORE CITY HEALTH DEPARTMENT

72 08385

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>(MICHAELS)</b> OR MIHELIC <b>GLORIA SALVICH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00</b> 127 S. Exeter St. Apt. 5K		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 27 1972 3:55p</b> M.	
6. SEX <b>female</b>	7. RACE <b>white</b>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>302</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>May 6, 1912</b>		10. AGE (In years last birthday) <b>60</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Mihelic</b>		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WW DISABLED</b>	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Victoria / SADOR</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>ND</b>		17. SOCIAL SECURITY NO. <b>095-144849</b>	
18. INFORMANT <b>William Slavich</b>		ADDRESS <b>Rt 1 Box 463 Bath Pa</b>	
19. <b>412.4</b> CAUSE OF DEATH <b>096-07-486</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>PARTIAL</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W P Mulloy</b> EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b>		DATE SIGNED <b>8-28-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-31-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Boston</b>	
25C. FUNERAL DIRECTOR <b>WM. FIALKOWSKI</b>		ADDRESS <b>2007 EASTERN AVENUE</b>	

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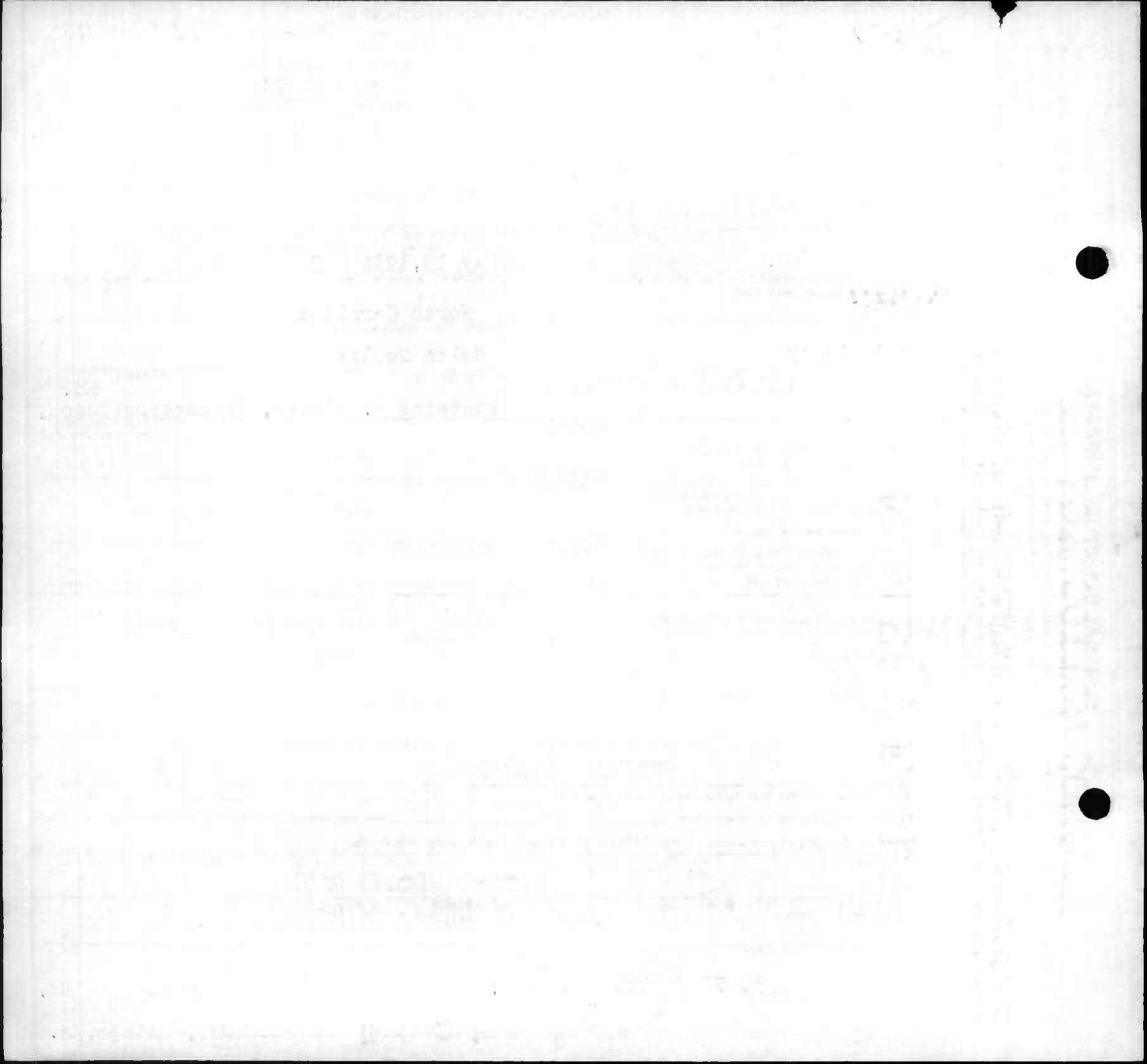
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

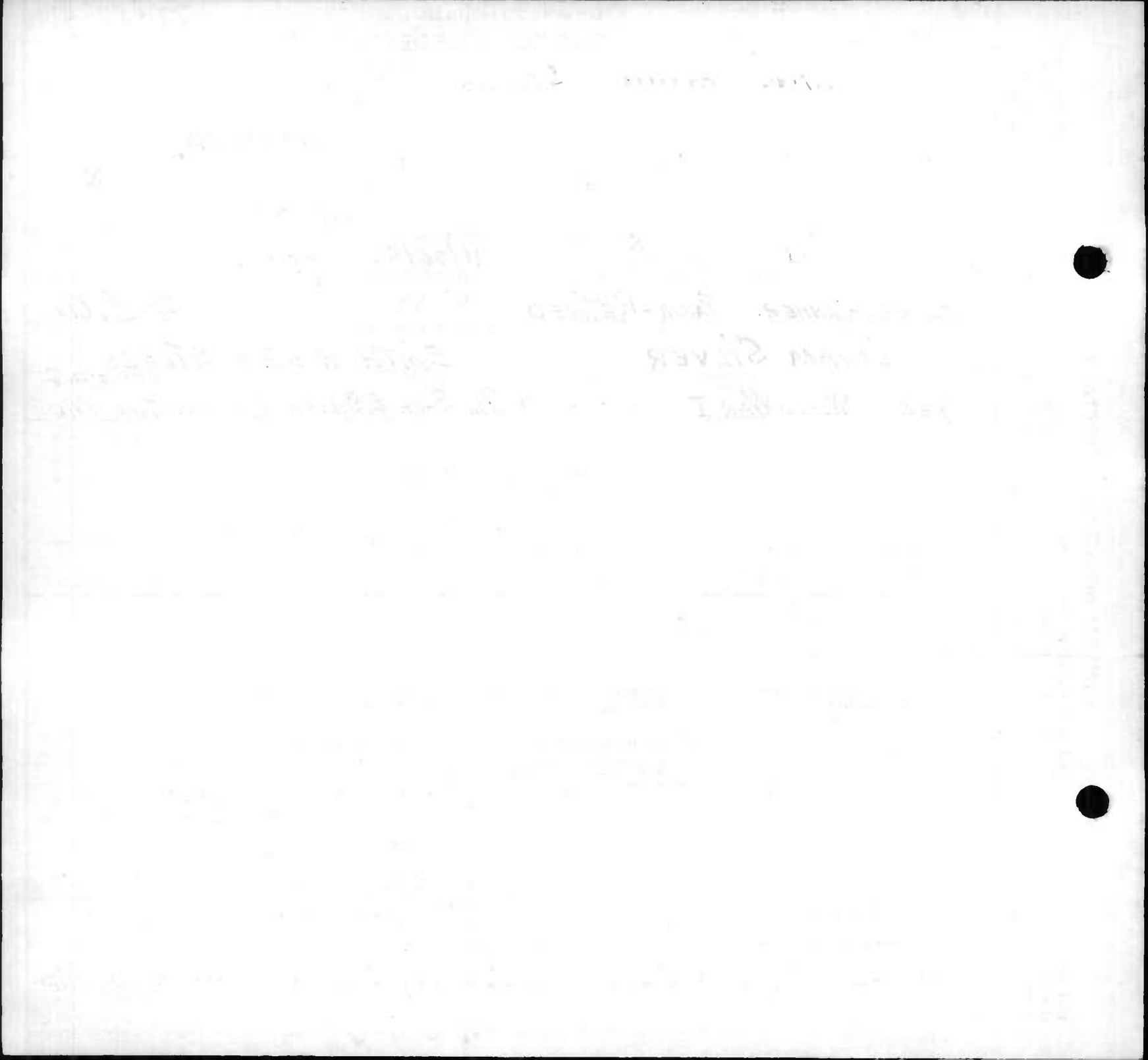
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08286</u>	
D-250 72 08286				STATE OF MARYLAND-DHMH	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
MAURY DISNEY		8.28.72 11:55 A.M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital 48 Baltimore MD	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		5. SEX		6. RACE	
Box: 234 Chesapeake Beach MD		M		Cauc	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
		May 15, 1914		58 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				North Carolina	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Fred Disney		Helen Dudley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Fontaine M. Disney, Chesapeake Beach, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, aethenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		4 mos	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		Uremia & Pulmonary insufficiency			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		8.22.72		Dysphagia	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR	
		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8.17. 1972 to 8.28. 1972					
that (I) (we) last saw the deceased alive on 8.28. 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
[Signature]		8.28.72		AHSAN S. KHAN	
23D. ADDRESS		23E. FUNERAL DIRECTOR		23F. ADDRESS	
1245 Greystone Rd Calvert Md 21227		BUCHANAN FUNERAL HOME, Owings, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		8/30/82		Southern Memo; Gardens Dunkirk Calvert Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 31 1972		[Signature]		[Signature]	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08387	
S-322		72 08387		CERTIFICATE OF DEATH	
BIRTH NO.		NAME OF DECEASED (Type or Print) <i>Silver Francis Stokes</i>		DATE AND HOUR OF DEATH <i>8/26/1972</i> <i>6-28 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>HARFORD</i>		C. CITY OR TOWN <i>Darlington</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i> <i>48</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>R.D. #1</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/06/98</i>	9. AGE (In years last birthday) <i>73 yrs</i>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER-CANNER.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>FARM-RETIRED</i>		11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>WILLIAM SILVER</i>		14. MOTHER'S MAIDEN NAME <i>EDITH WISTER STOKES</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WORLD WAR I</i>		16. SOCIAL SECURITY NO. <i>184-10-5624</i>		17. INFORMANT <i>Mrs. SARA E. SILVER, DARLINGTON, MD.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>157.9 I</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of</i> (B) <i>pancreas &amp; metastases</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/24/1972</i> to <i>8/26/1972</i> that (I) (we) last saw the deceased alive on <i>8/26/1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Bhargava</i>		23B. DATE SIGNED <i>8/26/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>Bhargava &amp; Desai</i>		23D. ADDRESS <i>Maryland General Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>Aug. 29 1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>DARLINGTON CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>DARLINGTON, HARFORD, MD.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>AUG 31 1972</i>		25B. NAME OF REGISTRAR <i>Francis Stokes</i>		25C. FUNERAL DIRECTOR <i>R. Hadjiaz Michael Howard Spass M.D.</i>	

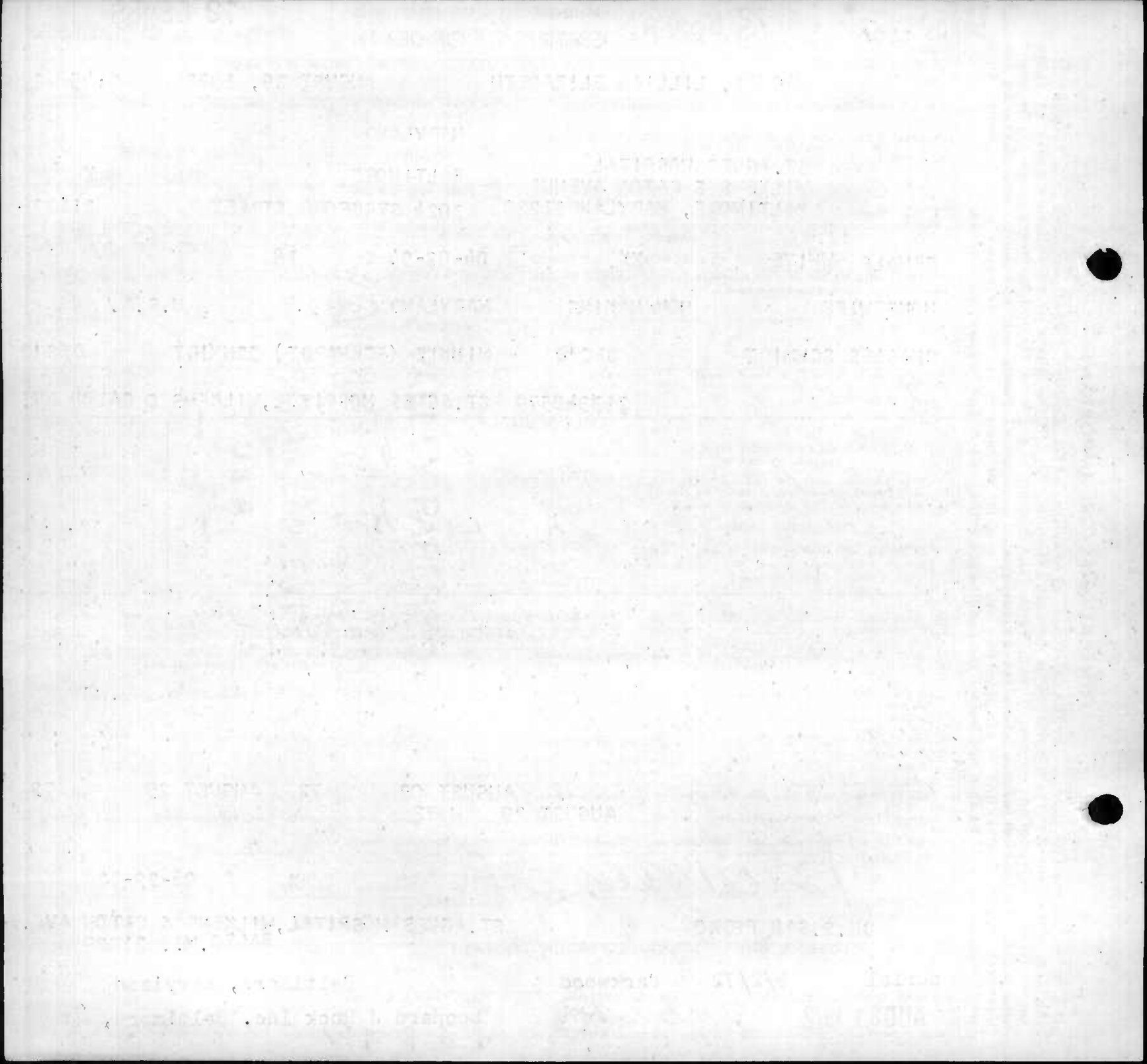




**FUNERAL DIRECTOR: IMPORTANT**

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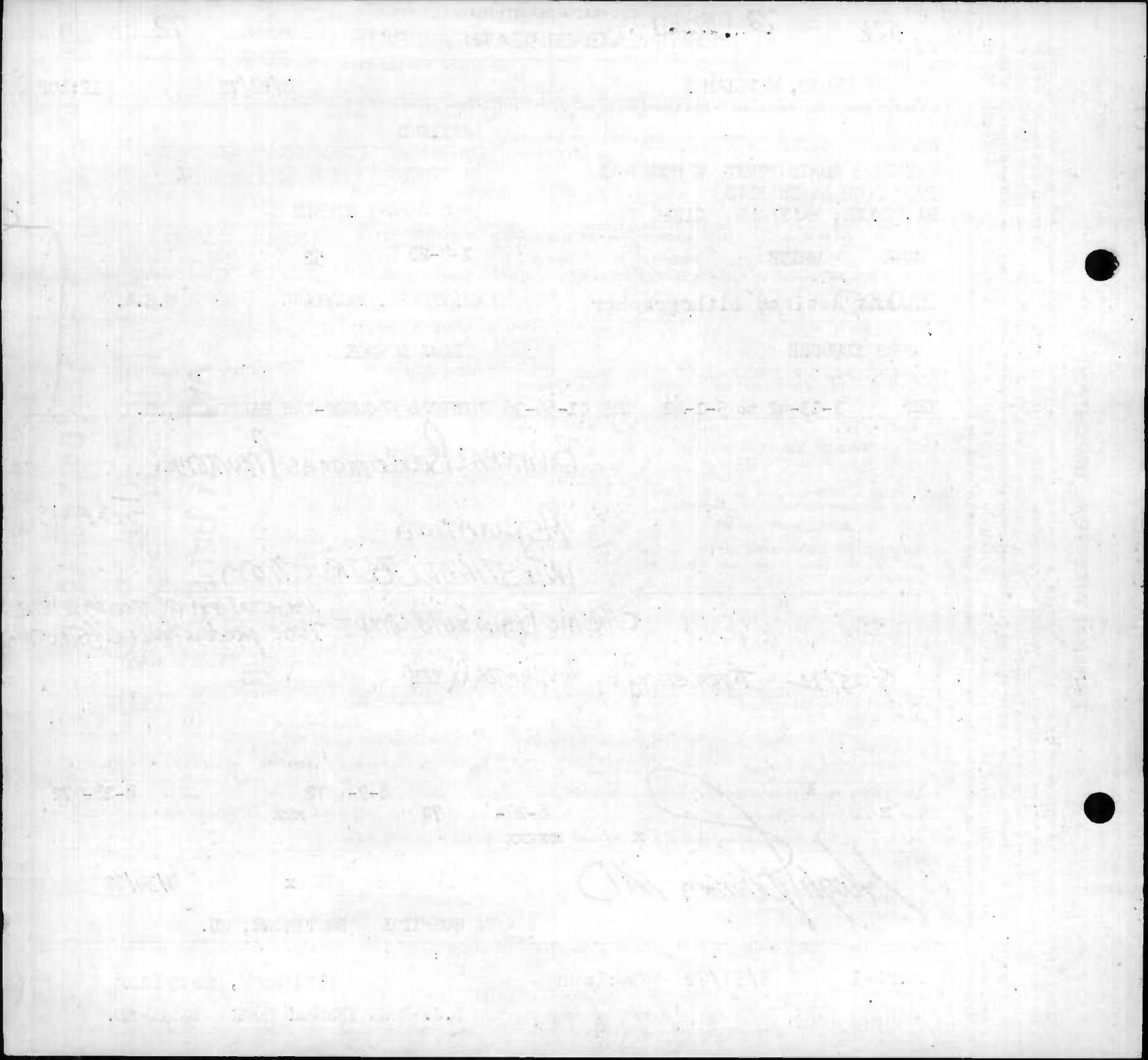
W-256		72 08388		BALTIMORE CITY HEALTH DEPARTMENT		72 08388		REG. NO. STATE OF MARYLAND-DEMR		
BIRTH NO.					1. NAME OF DECEASED (Type or Print)					
					WAGNER, LILLIAN ELIZABETH					
2. DATE AND HOUR OF DEATH					AUGUST 29, 1972 9:45 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229					A. STATE MARYLAND					
					B. COUNTY 2006					
C. CITY OR TOWN BALTIMORE					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
E. STREET AND NUMBER 3024 STAFFORD STREET					21223					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04-03-94	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY HOME MAKING		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES SCHMIDT					14. MOTHER'S MAIDEN NAME MINNIE (ECKHARDT) SCHMIDT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 213340579		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE			
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH C.U.A - A.S.C.V.D - DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cancer R. hand due to complete occlusion of radial Artery					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from AUGUST 09 1972 to AUGUST 29 1972, that (I) (we) last saw the deceased alive on AUGUST 29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE S. S. San Pedro					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 08-29-72		
23C. PHYSICIAN'S NAME (Type) DR. S. SAN PEDRO					23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE. BALTO MD 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/2/72		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972					25B. NAME OF REGISTRAR S. S. San Pedro		25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc. Baltimore, Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

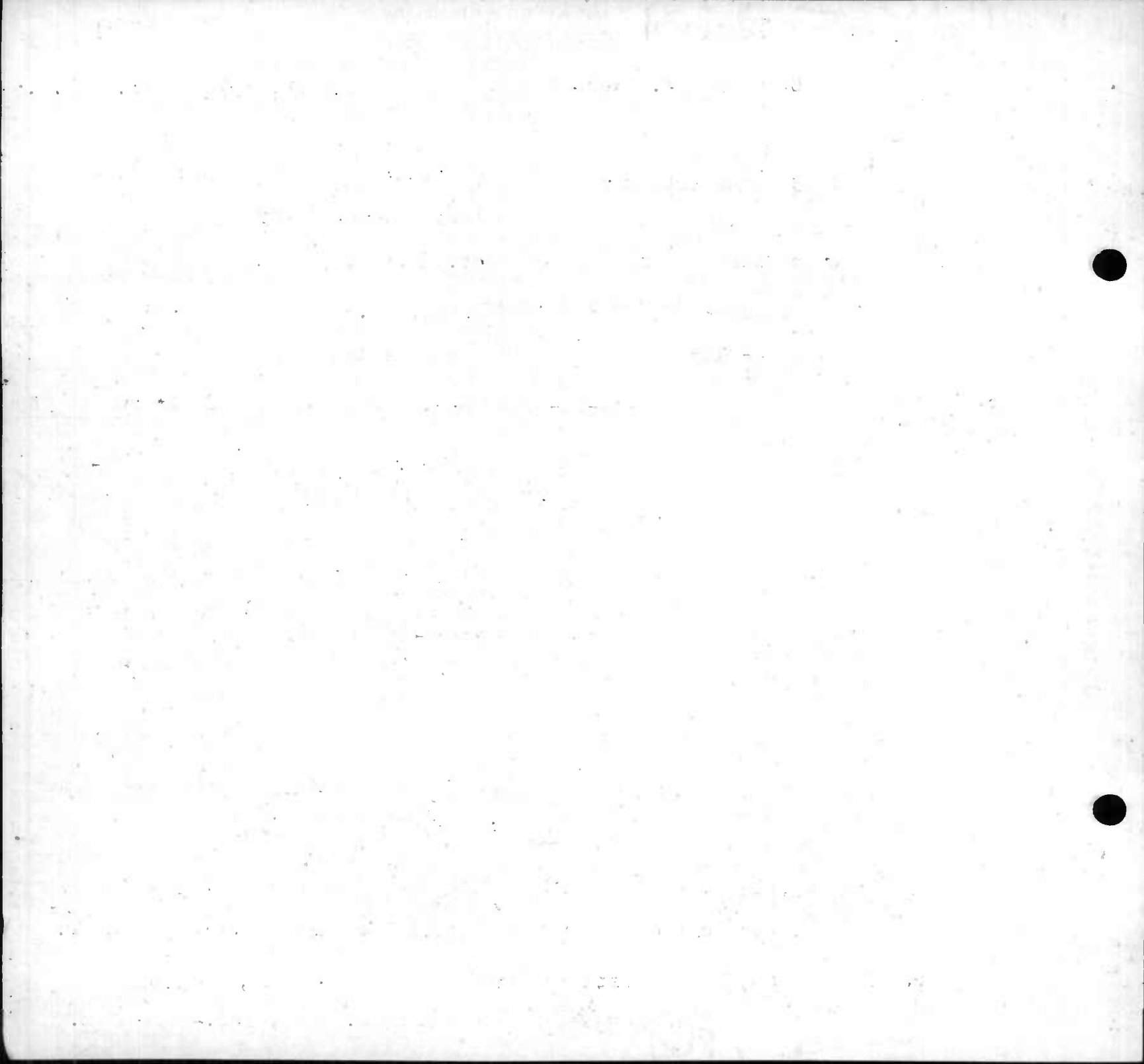
Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. <u>72 08289</u>	
BIRTH NO. <u>Y-526</u> <u>72.08389</u>				STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print) <b>YOUNGER, WILLIAM G</b>				2. DATE AND HOUR OF DEATH <b>8/28/72</b> <b>12:10P M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>VETERANS ADMINISTRATION HOSPITAL</b> <b>3900 LOCH RAVEN BLVD</b> <b>BALTIMORE, MARYLAND 21218</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>6900 CONLEY STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-8-20</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Lithographer</b>				11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN YOUNGER</b>				14. MOTHER'S MAIDEN NAME <b>EDNA M EMGE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1-13-42 to 5-1-42</b>				16. SOCIAL SECURITY NO. <b>215 01-66-38</b>		17. INFORMANT <b>CLINICAL RECORDS-VAH BALTIMORE, MD.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bacterial Pseudomonas Pneumonia</b> <b>Aspiration</b> <b>INTESTINAL OBSTRUCTION</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic Brain Syndrome - ingestion of toothpaste</b> <b>Tube producing OBSTRUCTION</b>							
19A. DATE OF OPERATION <b>8/25/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tracheostomy for Respiratory Rx</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unknown</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unknown</b>			
21D. TIME OF INJURY (APPROX.) <b>Unknown</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Swallowed toothpaste tube</b>			
22. I certify that (A) (this hospital) attended the deceased from <b>8-9-1972</b> to <b>8-28-1972</b> , that (B) (we) last saw the deceased alive on <b>8-28-1972</b> and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) <b>not</b> view the body after death.							
23A. SIGNATURE <i>Hugh Johnson MD</i>				23B. DATE SIGNED <b>8/30/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Hugh Johnson MD</b>				23D. ADDRESS <b>VA HOSPITAL BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/31/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <i>Richard Johnson</i>		25C. FUNERAL DIRECTOR <b>L. J. RUGG FUNERAL HOME BALTO MD.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08330</b>	
W-640 72 08330				STATE OF MARYLAND-DEPT	
BIRTH NO.				BIRTH NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<b>Clarence B. WORLEY</b>			<b>August 29, 1972 11.30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
<b>1623 Wadsworth Way</b>			<b>Maryland</b>		
5. SEX			6. DATE OF BIRTH		9. AGE (In years last birthday)
<b>male</b>	<b>caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	<b>Nov. 23, 1887</b>		<b>84</b>
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<b>retired Restaurant owner</b>			<b>Balto, Md.</b>		<b>USA</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<b>David Worley</b>			<b>Mary E Collins</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
<b>No</b>			<b>214-30-3466</b>		<b>Mrs. Myrtle Bell, 1623 Wadsworth Way</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
<b>ANTECEDENT CAUSES</b>			<b>acute myocarditis</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>arteriosclerosis</b>		
<b>II</b>			<b>chronic white</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			<b>pulmonary embolism</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
<b>NO</b>				<b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<b>NO</b>					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 14</b> 19 <b>69</b> to <b>August 29</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>August 29</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<b>Dr. Leo Schlenger MD</b>				<b>8/30/72</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<b>Dr. Leo Schlenger</b>				<b>6001 Loch Raven Blvd, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Burial</b>		<b>9/1/72</b>		<b>Lorraine Park</b>	
24D. LOCATION (City, town, or county)		24E. LOCATION (City, town, or county)		24F. LOCATION (City, town, or county)	
<b>Baltimore, Maryland</b>		<b>Baltimore, Maryland</b>		<b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>AUG 31 1972</b>		<b>Disney H. H. H.</b>		<b>Leonard J. Ruck, Inc.-Balto, Md.</b>	





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VS 150-REV. 1/1/68



July 1, 1909

xxxxxxx Insurance  
Wells Fargo & Co.  
U.S.A.

John A. Ford

121-122  
xxxxxxx Insurance  
Wells Fargo & Co.  
U.S.A.

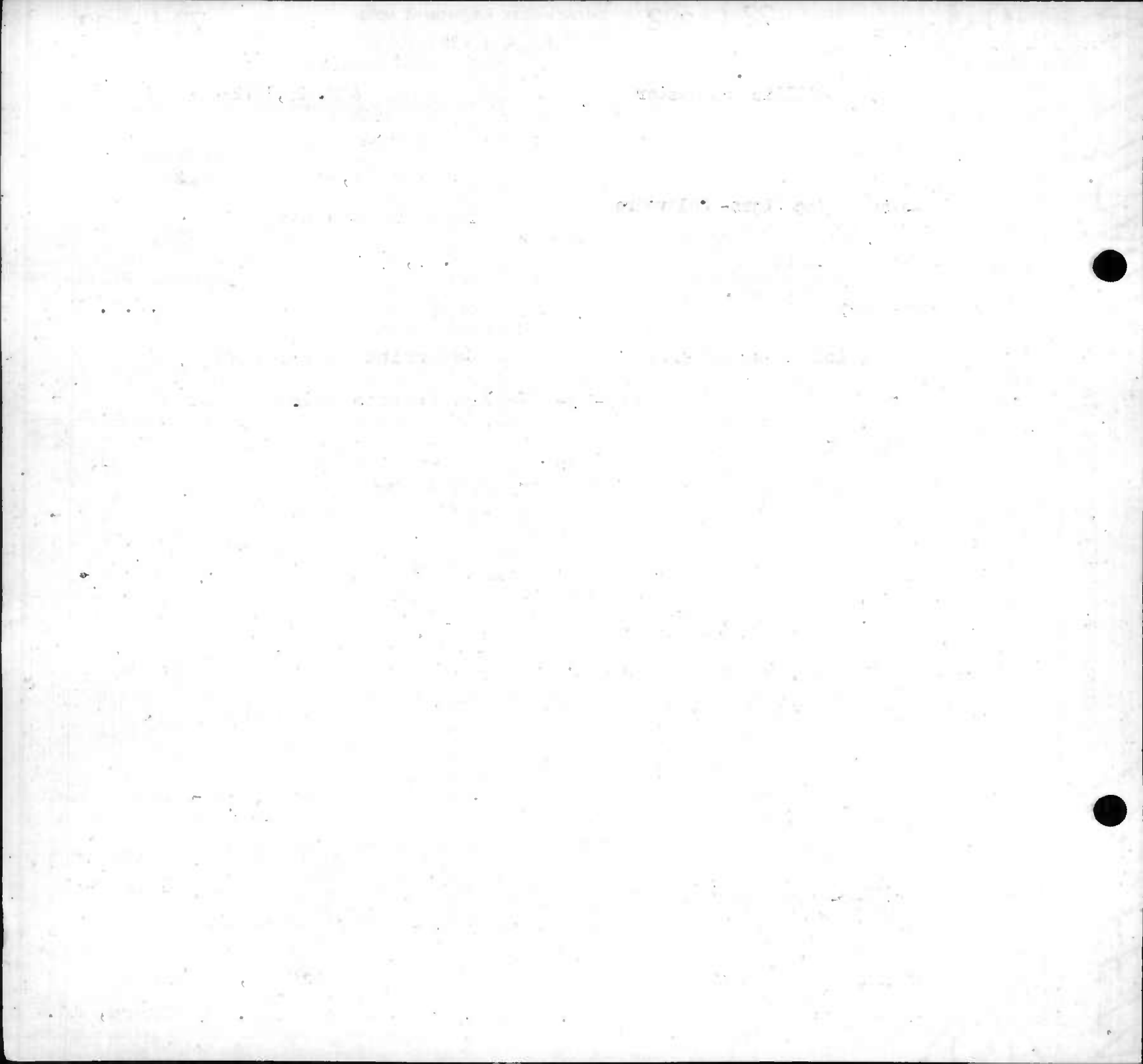
xxxxxxx Insurance  
Wells Fargo & Co.  
U.S.A.

xxxxxxx Insurance  
Wells Fargo & Co.  
U.S.A.

# FUNERAL DIRECTOR: IMPORTANT

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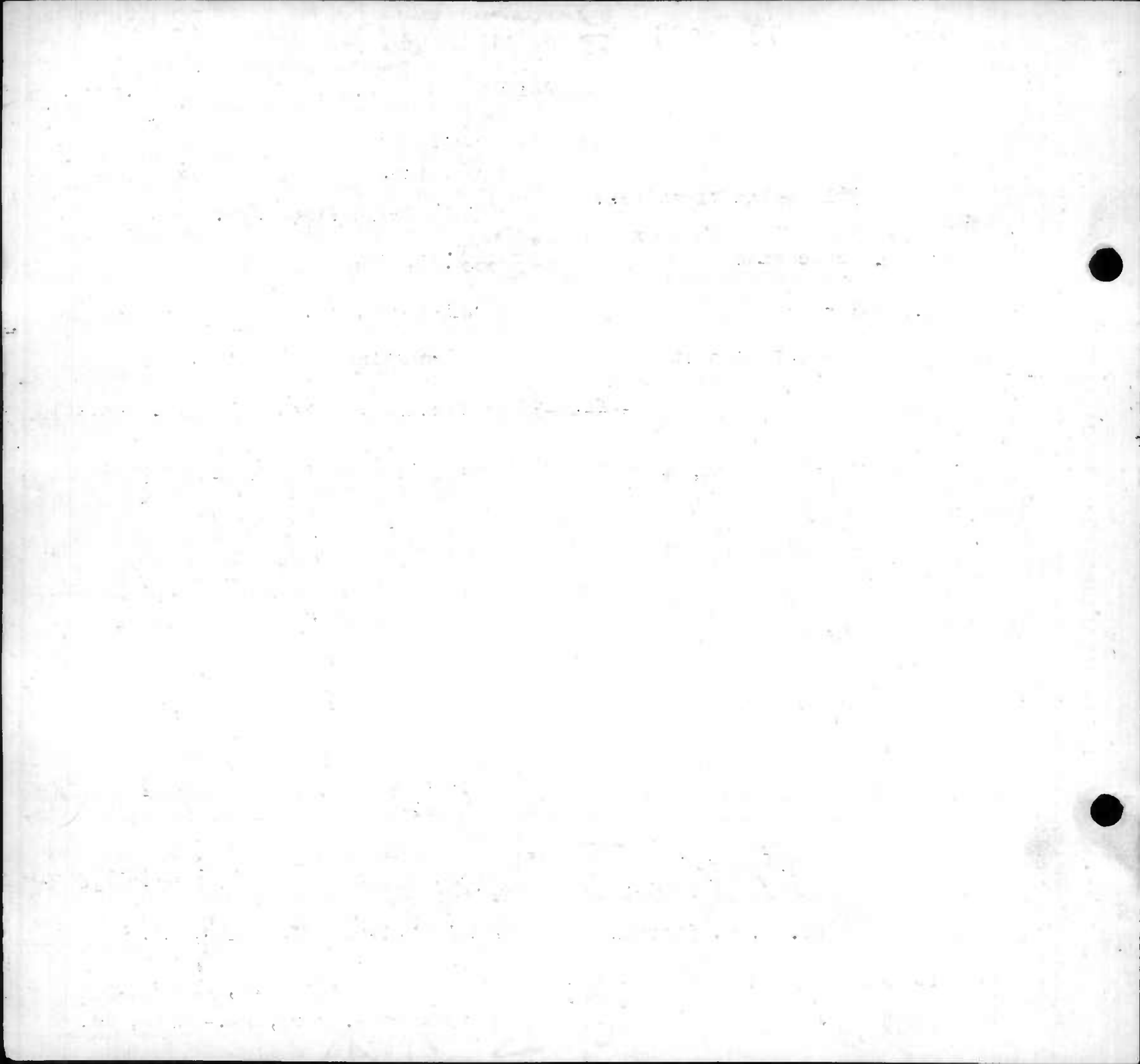
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08392	
72 08392				STATE OF MARYLAND DEPT.	
BIRTH NO. 8-523				CITY OF BALTIMORE	
1. NAME OF DECEASED (Type or Print) <b>H. William Baumeister</b>			2. DATE AND HOUR OF DEATH <b>Aug. 29, 1972 17:15 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>90 House In The Pines- Belevedere</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2706</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90</b>			C. CITY OR TOWN <b>Baltimore,</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>5402 Elsrode Ave</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1908</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>William H Baumeister Sr</b>		
14. MOTHER'S MAIDEN NAME <b>Catherine Schwarzkopf</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>217-03-3599</b>			17. INFORMANT ADDRESS <b>Mrs Rebecca Weiss Same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebral atrophy</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>encephalitis</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>May 15 1972</b> to <b>Aug 29 1972</b> , that (I) (we) last saw the deceased alive on <b>Aug 29 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. B. Cohen</b>			23B. DATE SIGNED <b>8/30/72</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS <b>3501 ST Paul ST 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/2/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc. Baltimore, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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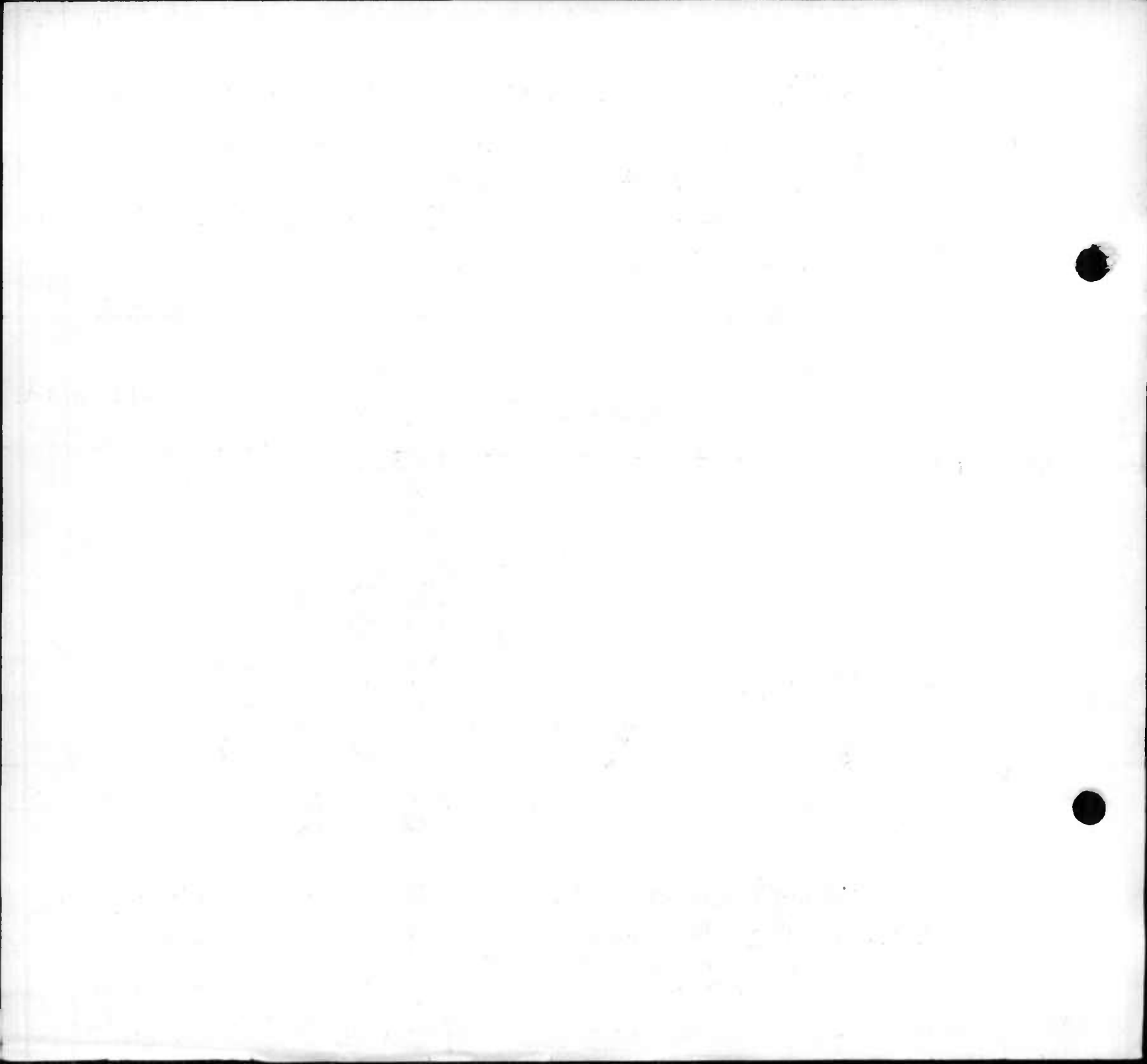
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08393	
E-212 72 08393				STATE OF MARYLAND-DEMH	
BIRTH NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		REGINA ESPOSITO		Aug. 30, 1972 12.50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
00 5612 Belle Vista Ave.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
female		caucasian		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. AGE (In years last birthday)	
Nov. 30, 1894		77		11. BIRTHPLACE (State or foreign country)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
housewife		Baltimore, Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Robert Schmidt		Ernestine ?		no	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
216-48-3567		Mrs. Ida May Esposito, 3516 Rosekemp Av			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/17 1949 to 8/30 1972, that (I) (we) last saw the deceased alive on 8/28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. L. B. Stevens				8/30/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. L. B. Stevens				3400 Erdman Ave, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/1/72		Oaklawn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 31 1972		Sidney Whiston		Leonard J. Ruck, Inc.-Bal to, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-460		72 08394		BALTIMORE CITY HEALTH DEPARTMENT		72 08394	
BIRTH NO.		72 08394		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		NAYLOR, MINNIE		2. DATE AND HOUR OF DEATH		3:30 AM 29 AUG 72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP. OF BALTO. INC.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND BALTO 5300		C. CITY OR TOWN BALTO. CITY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 6059 FALLS RD. 21209			
5. SEX F	6. RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/92	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDRICK LAABES		14. MOTHER'S MAIDEN NAME GOMPH.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-74-9525	
17. INFORMANT WALTER H NAYLOR		ADDRESS 6059 FALLS ROAD		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Prob. Septicemia / Shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gangrene Bowel		(B) DUE TO, OR AS A CONSEQUENCE OF: Thrombosis Celiac Plexus		24 hrs. 24-36 hrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASCVD		19A. DATE OF OPERATION 28 AUG 72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 28 AUGUST 19 72 to 29 AUGUST 19 72 that (I) (we) last saw the deceased alive on 29 AUG 19 72 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Michael Schultz		23B. DATE SIGNED 29 AUG 72			
23C. PHYSICIAN'S NAME (Type) SCHULTZ, MICHAEL S.		23D. ADDRESS SINAI HOSP. BALTIMORE		23E. DATE SIGNED 29 AUG 72			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-1-72		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, BALTO Md	
25A. DATE REC'D BY HEALTH DEPT. AUG 31 1972		25B. NAME OF REGISTRAR Audrey Whitson		25C. FUNERAL DIRECTOR Frank W. Sutz		ADDRESS 814 W 36th St	





## 72 08395 CERTIFICATE OF DEATH

REG. NO.

72 08395

STATE OF MARYLAND-DEMH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rowe, Marie

2. DATE AND HOUR OF DEATH

8/26/72

12 50 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1933 Dineen Drive 21222

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11-4-19

9. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Walker

14. MOTHER'S MAIDEN NAME

Stella Winters

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

4940 Eastern Avenue

BCH - RECORDS

Baltimore, Maryland 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (A) (this hospital) attended the deceased from Aug. 22 1972 to Aug 26 1972,  
that (B) (we) last saw the deceased alive on Aug 26 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (A) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. Sankarati

M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

8/26/72

23C. PHYSICIAN'S  
NAME (Type)

MENDI SANKARATI

M.D.

DEGREE

23D. ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

8-29-72

24C. NAME of CEMETERY or CREMATORY

Frostburg Memorial Park

24D. LOCATION

(City, town, or county)

(State)

Frostburg, Allegany, Md.

25A. DATE REC'D BY HEALTH DEPT.

AUG 31 1972

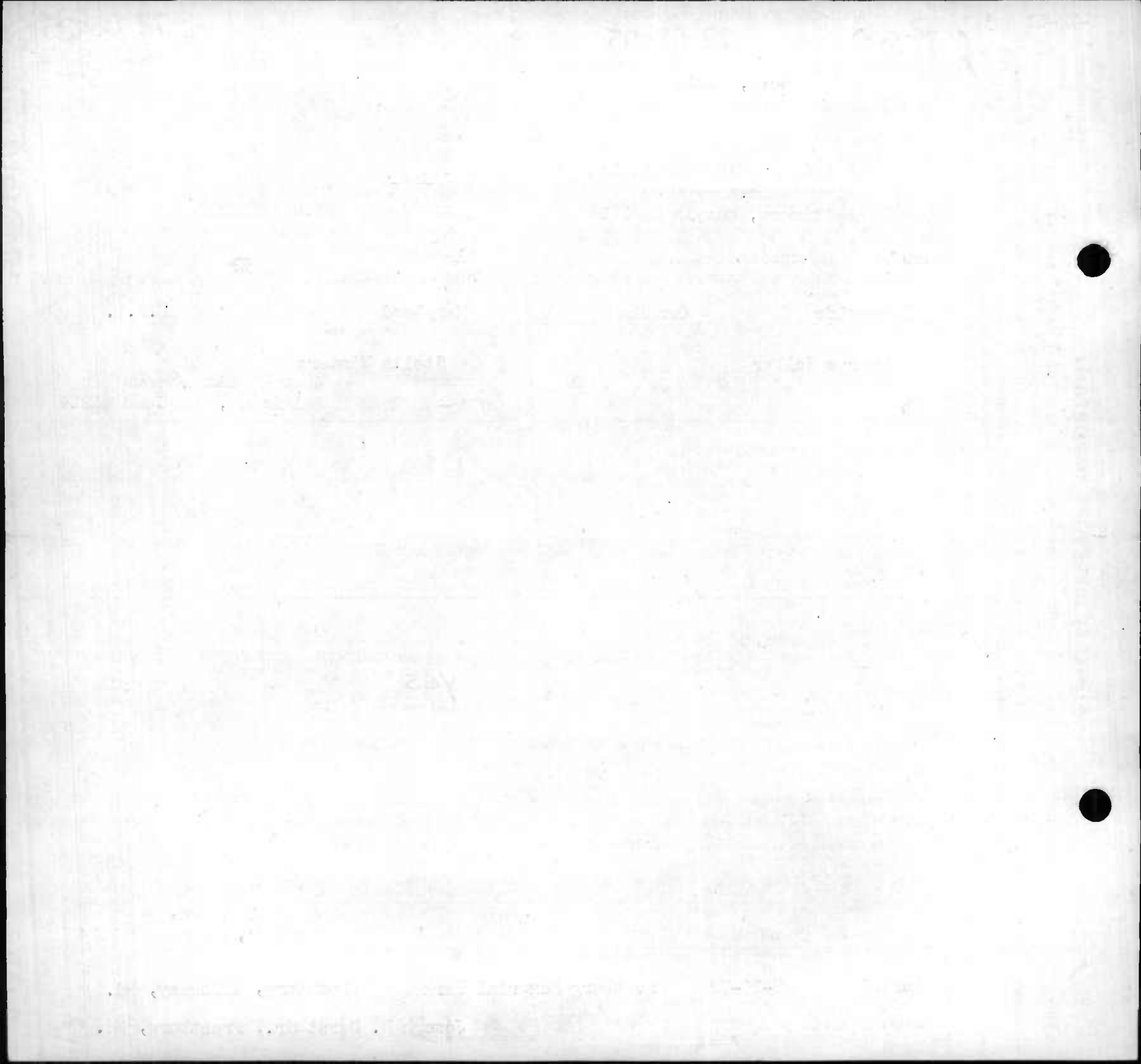
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Joseph R. Dyrst Sr., Frostburg, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-625		72 08396		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08396		4	
BIRTH NO. 72-12028		CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL GARGANO, PATRICIA</u>		2. DATE AND HOUR OF DEATH <u>8/16/72</u> <u>1 22 10</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>(MOTHER'S ADDRESS)</u>							
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 GREENSPRING + BELVEDERE AVES</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>SINAI HOSP OF BALTO.</u>		C. CITY OR TOWN <u>BALTO</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>GIRL</u>		6. RACE <u>CAU.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/16/72</u>		9. AGE (in years last birthday) <u>25 min</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NOT EMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANDREW GARGANO</u>				14. MOTHER'S MAIDEN NAME <u>PATRICIA BEAL</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>SINAI HOSP.</u>				ADDRESS	
18. <u>76391</u>		CAUSE OF DEATH <u>PREMATURITY</u> (A) IMMEDIATE CAUSE <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>PROL.</u> (B) <u>AMNIOTIS</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> (C) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 16 - 1 PM 19 72</u> to <u>220 AM AUG 16 19 72</u> that (I) (we) last saw the deceased alive on <u>AUG 16 2 15 PM 19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Raymond J. Lunan</u>		23B. DATE SIGNED <u>8/16/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Arnold D. Luterman</u>		23D. ADDRESS <u>SINAI HOSP OF BALTO.</u>		23E. FUNERAL DIRECTOR <u>Raymond J. Lunan</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>8-24-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Catholic Burial M. 43rd St</u>		24D. LOCATION (City, town, or county)		(State)	
25A. DATE REC'D BY HEALTH DEPT. <u>AUG 31 1972</u>		25B. NAME OF REGISTRAR <u>Lidney Johnson</u>		25C. FUNERAL DIRECTOR <u>Raymond J. Lunan</u>		25D. ADDRESS <u>8175 ...</u>		25E. ...	

858

7

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08397

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Birtha Heynes

2. DATE  
OF  
DEATHKnown ☐  
Found ☒  
Estimated ☐Month  
Day  
YearHour  
P. M.

7

27

72

P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

903 W. Saratoga St. Apt. 6

3. DATE  
PRONOUNCED DEADMonth  
Day  
YearHour  
P. M.

7

27

72

2:20 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1801

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

UNKNOWN

10. AGE (In years  
last birthday)

63

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

903 W. Saratoga St. Apt. 6

11. BIRTHPLACE (State or foreign country)

UNKNOWN

12. CITIZEN OF  
WHAT COUNTRY?

UNKNOWN

13. FATHER'S NAME

UNKNOWN

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

UNKNOWN

14B. KIND OF BUSINESS OR INDUSTRY

UNKNOWN

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

17. SOCIAL  
SECURITY NO.

18. INFORMANT

BAL CITY MED

ADDRESS

19. 412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular  
DUE TO, OR AS A CONSEQUENCE OF: disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)W.P. Mulloy  
M.D.  
William P. Mulloy, M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
7-28-7224A. BURIAL CREMATION,  
REMOVAL (9-2-72)

24B. DATE

8-25-72

24C. NAME OF CEMETERY or CREMATORY

VORM. ANASTAS-SEARD

24D. LOCATION

(City, town, or county)

(State)

BALT, MD

25A. DATE REC'D BY HEALTH DEPT.

AUG 31 1972

25B. NAME OF REGISTRAR

Sidney H. Weston

25C. FUNERAL DIRECTOR

Raymond J. Curran

ADDRESS

817 S. Calver St. Baltimore, Md 21204

1941-1942

United States  
Maritime  
California

San Francisco

72 08398

STATE OF MARYLAND-DEMH

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08398

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Davis

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

P. M.

7

27

72

P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

155 W. Saratoga St.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

7

27

72

4:45 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

401

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

UNKNOWN

10. AGE (In years  
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

155 W. Saratoga Street

11. BIRTHPLACE (State or foreign country)

UNKNOWN

12. CITIZEN OF  
WHAT COUNTRY?

UNKNOWN

13. FATHER'S NAME

UNKNOWN

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

UNKNOWN

14B. KIND OF BUSINESS OR INDUSTRY

UNKNOWN

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

BALTIMORE, MED. EXAMINER

19. 571.81

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty metamorphosis of liver  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)22E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)W.P. Mulloy M.D.  
William P. Mulloy, M.D.CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
7-28-7224A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

8-25-72

24C. NAME OF CEMETERY or CREMATORY

Voorhies Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

AUG 31 1972

25B. NAME OF REGISTRAR

Sidney H. Hooton

25C. FUNERAL DIRECTOR

Raymond J. Hooton

ADDRESS

817 S. Calvert St.  
Baltimore, Md. 21201

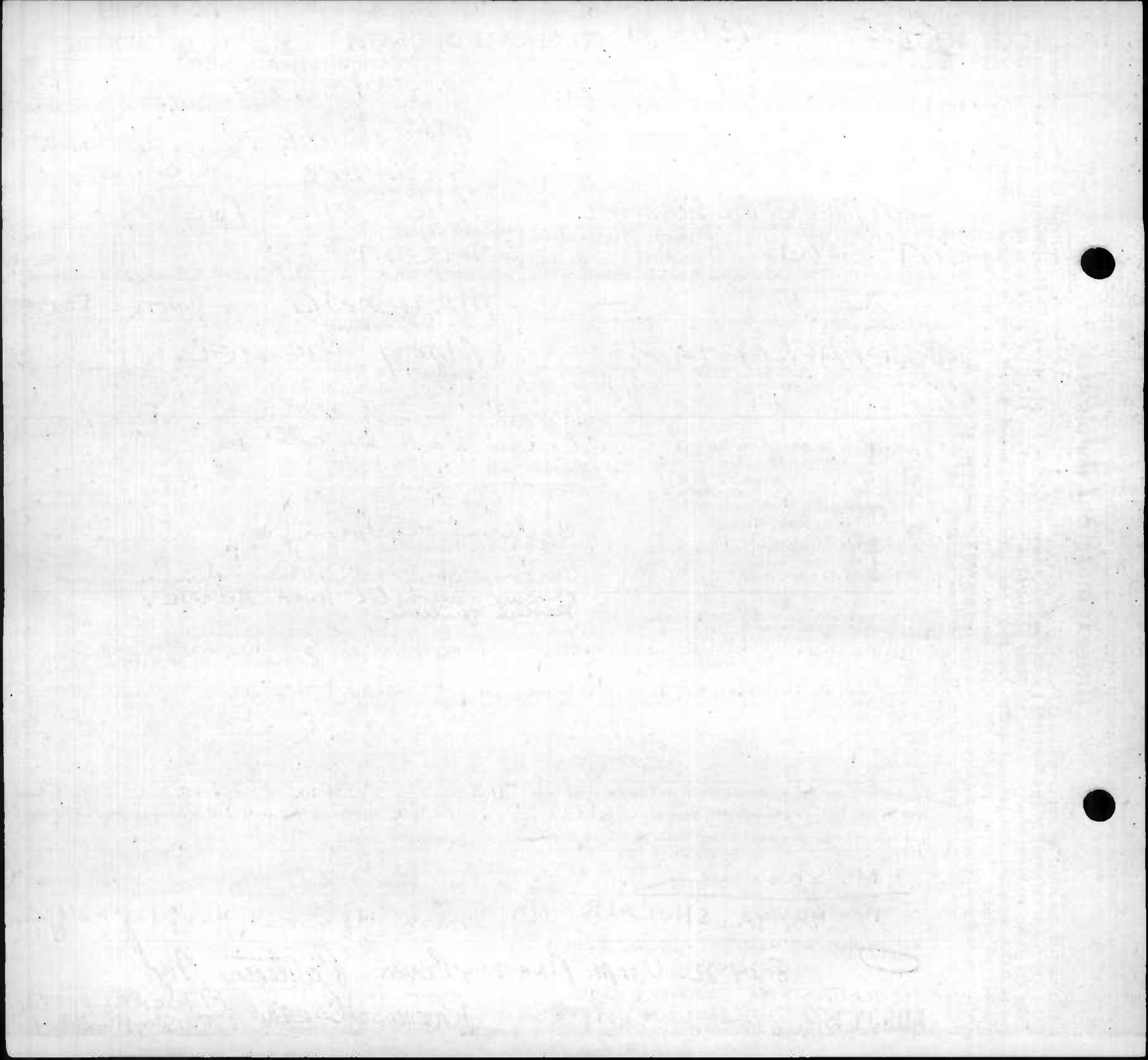


8-25-11 11:10 AM

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-135		72 08399		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08399		STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FREDERICK R. KAPTAIN</b>				2. DATE AND HOUR OF DEATH <b>8/13/72</b> <b>3 30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1348</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>		E. STREET AND NUMBER <b>1410 Union Ave.</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-12-17</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
13. FATHER'S NAME <b>JOSEPH KAPTAIN</b>				14. MOTHER'S MAIDEN NAME <b>MARY HIEMEL</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. <b>421.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Cardio-vascular collapse</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Bacterial Endocarditis</b> (B) <b>Chronic obstructive lung disease</b> (C) <b>chronic alcoholic liver disease</b> <b>Renal failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>7/5</b> 19 <b>72</b> to <b>8/13</b> 19 <b>72</b> , that <del>the</del> (we) last saw the deceased alive on <b>8/13</b> 19 <b>72</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>M. Shocair</b> M.D. OEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>MAWYA SHOCAIR MD</b> OEGREE				23D. ADDRESS <b>Union Memorial Hospital Baltimore Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>8-24-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>U.S.M. ANATOMY BOARD</b>		24D. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Johnston</b>		25C. FUNERAL DIRECTOR <b>RAYMOND J. CURRAN</b>		ADDRESS <b>8175 SCARBOROUGH TOWSON, MD 21204</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08400		72 08400	
CERTIFICATE OF DEATH				STATE OF MARYLAND-DEMH		REC. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
Marian F. Jones		August 30 1972 5:45 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Maryland General Hospital				Md. Baltimore City 17-01			
4-8				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER			
F W				607 Pennsylvania Ave			
8. DATE OF BIRTH 9. AGE (In years last birthday)				10. CITIZEN OF WHAT COUNTRY?			
? 1898 83				11. BIRTHPLACE (State or foreign country)			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				12. CITIZEN OF WHAT COUNTRY?			
10B. KIND OF BUSINESS OR INDUSTRY							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				214-24-5037			
17. (INFORMANT)				ADDRESS			
chart							
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Myocardial Infarct			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from August 29 1972 to August 30 1972 that (1) (we) last saw the deceased alive on August 30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Michael Lee Walker M.D.				8/30/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Michael Lee Walker M.D.				Maryland General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/1/72		Mt Auburn Cemetery		Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
AUG 31 1972		Sidney Halstead		Adolphus Halstead		1206 W North Ave	

admitted to J.W.N.4 in 1967  
address 646 W. Franklin St

O-340

72 08401

STATE OF MARYLAND - DEMO  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08401

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>William Outlaw Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 29 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 29 72 11:40 p.m.</b>	
6. SEX <b>male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>12-12-45</b>		10. AGE (In years last birthday) <b>27</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William B. Outlaw Sr.</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1301</b>	
15. MOTHER'S MAIDEN NAME <b>Mary L. Lokemond</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>William B. Outlaw Sr. 1317 W. Lanvale</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of head</b>		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
23. DATE OF OPERATION <b>2</b>		24. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
27. TIME OF INJURY (APPROX.) <b>8 29 72 11:00 p.m.</b>		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>500 Blk. Hamburg Street</b>	
29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> (head)		30. HOW DID INJURY OCCUR? <b>Subject was shot.</b>	
31. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		32. ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b>	
33. DATE SIGNED <b>8/30/72</b>		34. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
35. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		36. DATE <b>9-1-72</b>	
37. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		38. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
39. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		40. NAME OF REGISTRAR <b>Sidney [Signature]</b>	
41. FUNERAL DIRECTOR <b>Wm C March</b>		42. ADDRESS <b>928 E. North Ave.</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

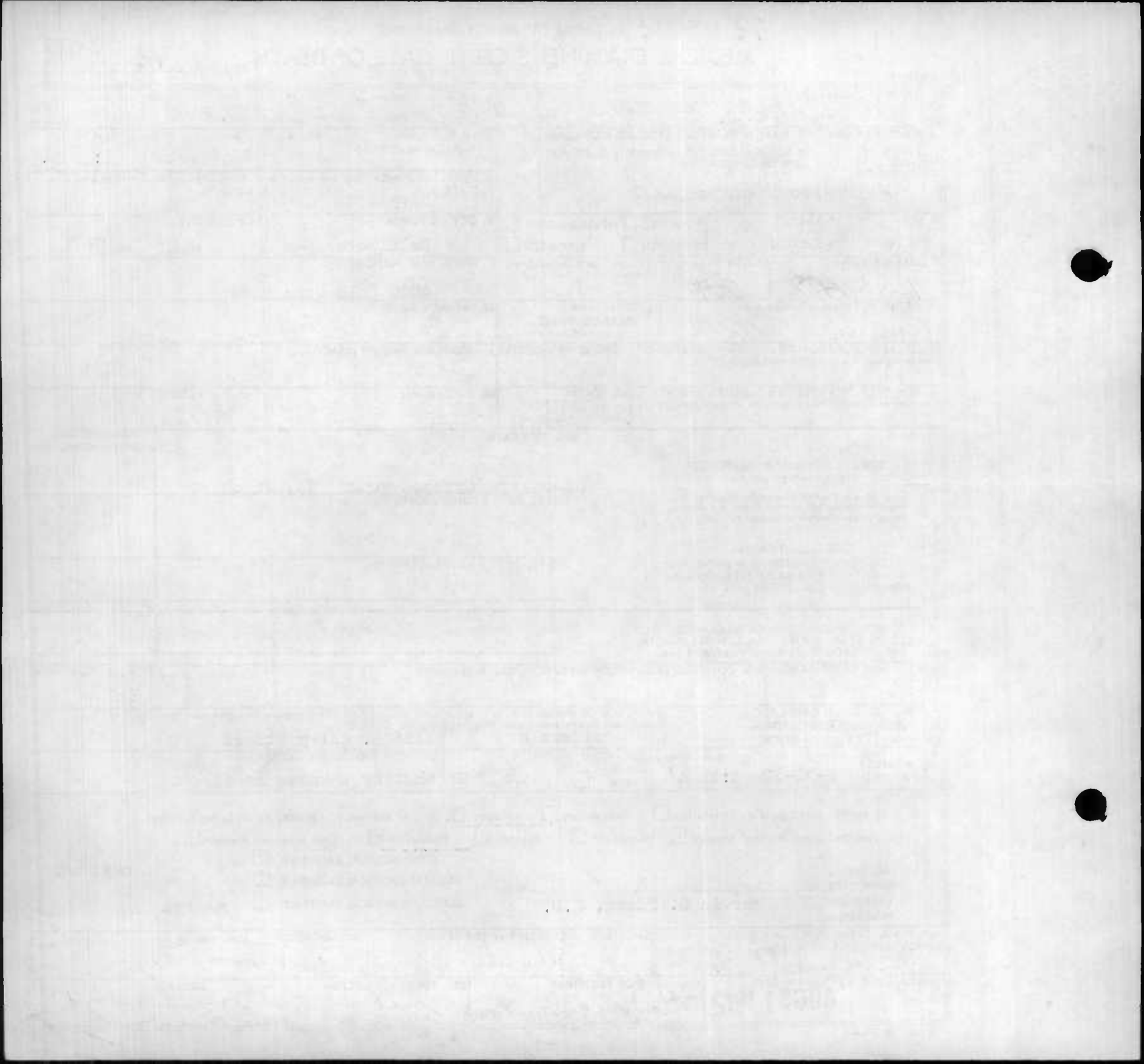
STATE OF MARYLAND-DEMH

REG. NO.

72 08402

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>PAYTON TISDALE</b> <i>AKA Payton Tisdale</i>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>August 31, 1972</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>August 31, 1972 1:30 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1608</b>	
9. DATE OF BIRTH <b>125748</b>		10. AGE (In years last birthday) <b>24</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTH PLACE (State or foreign country) <b>andrew sta</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Sarah M. Crox</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>214-111-1111</b>	
18. INFORMANT <b>Hegoline Tisdale</b>		ADDRESS <b>4020 Colbourne Road</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>sidewalk</b>	
22D. TIME OF INJURY (APPROX.) <b>8-31-72 1:12 A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1156 N. Carey Street</b>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 31, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-6-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney H. Houston</b>	
25C. FUNERAL DIRECTOR <b>Walter L. McCumby</b>		ADDRESS <b>2309 W. North Ave. Bkfst</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08403</b>
72 08403		<b>CERTIFICATE OF DEATH</b>		STATE OF MARYLAND-DEMD
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>ASHBY CRAWFORD</b>		8-31-72 <b>7 P</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOS PT.</b>		A. STATE <b>MARYLAND</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44</b>		B. COUNTY <b>2710</b>		
		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>529 ROSSITER AVE.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-14-98</b>	9. AGE (In years last birthday) <b>73</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(RET.) CARPENTER BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ALEC CRAWFORD</b>		14. MOTHER'S MAIDEN NAME <b>CLORINDA LAWSON</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>223-18-9151A</b>		17. INFORMANT <b>(WIFE) NANCY C. (SAME)</b>
18. <b>413.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> <b>acute Coronary Insufficiency 1 hr</b> <b>Angina Pectoris 5 yrs</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1967</b> to <b>8-31</b> 19 <b>72</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>7-20</b> 19 <b>72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <b>W. Benson, Jr. M.D.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>8-31-72</b>
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM BENSON</b>		23D. ADDRESS <b>3506 N Calvert Balt Md 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>9-5-72</b>	24C. NAME of CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>AUG 31 1972</b>		25B. NAME OF REGISTRAR <b>Sidney W. Jenkins</b>		25C. FUNERAL DIRECTOR <b>W. Jenkins &amp; Sons Co., Balto., Md.</b>

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12-20-40

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08404	
W-436 72 08404 CERTIFICATE OF DEATH				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILDER, SALLY RUTH		AUGUST 28, 1972 1:25 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		A. STATE MARYLAND BALTIMORE 21228 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3 GLENCOE AVENUE 5300			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	CAUCASIAN	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/25/89	82	CLEANER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RAILROAD		TENNESSEE		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ADOLPHAS ROEHL			MARGARET MILLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		212-12-0777		BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
CAUSE OF DEATH Severe Aortic Stenosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 24 19 72 to AUGUST 28 19 72, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 28 19 72 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
JOSE APTER M.D.				08 29 72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOSE APTER M.D.		CATON & WILKENS AVENUE 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		8/31/72		Lake View Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
AUG 31 1972		Sidney [Signature]		Edw. S. MacNabb Sons, Inc.	
				ADDRESS	
				301 Frederick Ave. Catonsville, Md.	

Burial

8/31/72

Lake View Park Cemetery, Carroll County, Md.

Interment after N.I.

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M-460

72 08405

STATE OF MARYLAND - DISTRICT  
BALTIMORE CITY HEALTH DEPARTMENT

72 08405

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRED MILLER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>821 N. Broadway</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 1, 1972 11:25 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>704</b>	
9. DATE OF BIRTH <b>AUG 15, 1920</b>		10. AGE (In years last birthday) <b>52</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN MILLER</b>		14. MOTHER'S MAIDEN NAME <b>LIZA MOORE</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DYE FACTORY</b>		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		20. INFORMANT <b>KATIE MAE HENDERSON</b> ADDRESS <b>2548 E. NORTH AVE</b>	

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			

20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: *Peter Lipkovic* M.D.  
EXAMINER'S NAME (Type): **Peter Lipkovic, M.D.**

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: **9/2/72**

24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/6/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>YORK MEMORIAL CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>CHARLOTTE N. C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <i>Sidney Johnston</i>		25C. FUNERAL DIRECTOR <b>CHARLES E. LAW</b>		ADDRESS <b>805 Madison</b>	

72 08405



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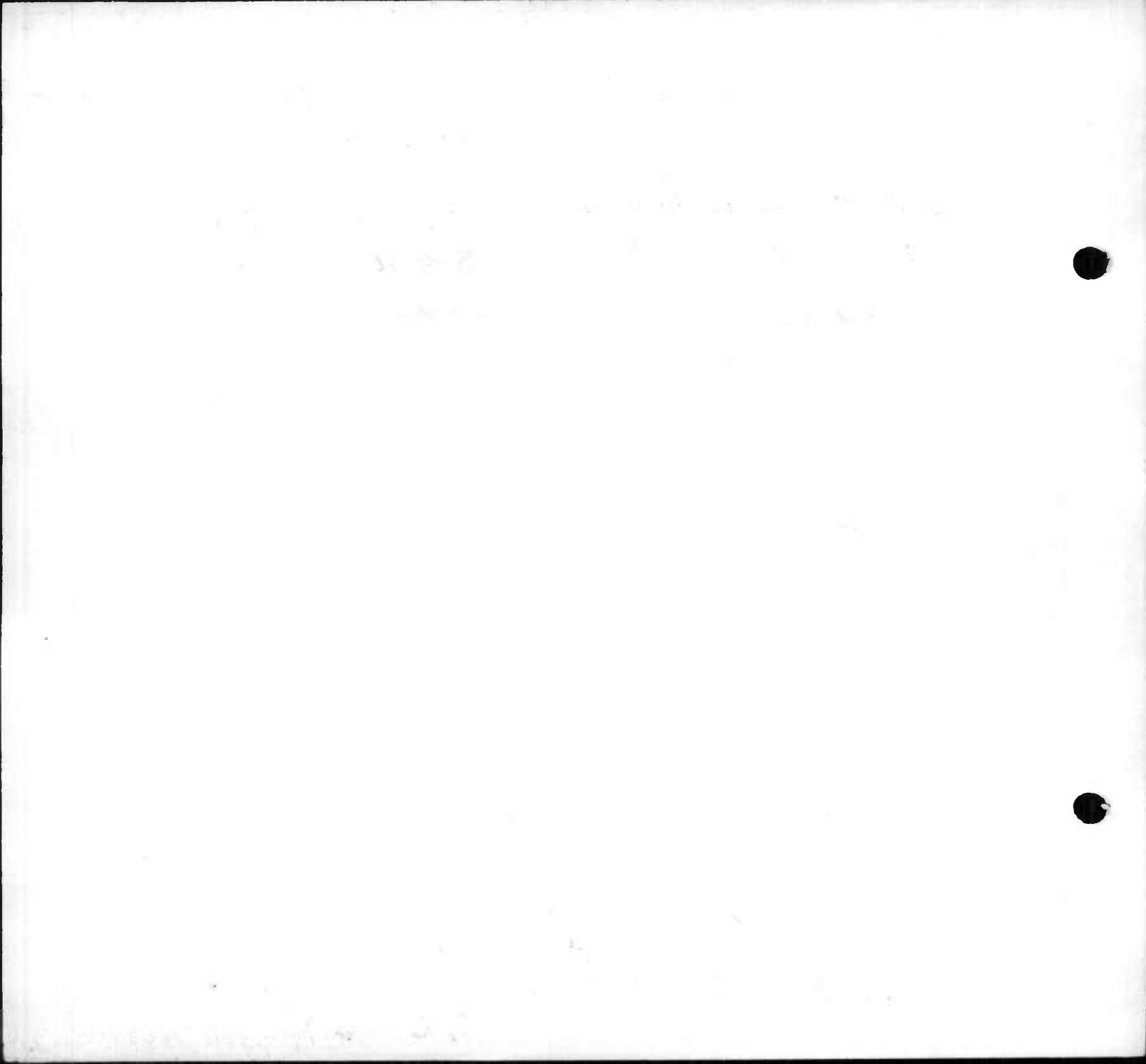
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08406		72 08406	
BIRTH NO. 8-346				72 08406		72 08406	
1. NAME OF DECEASED (Type or Print) BUTLER OLIVIA				2. DATE AND HOUR OF DEATH 9-1-72 6:45 A.M.		REG. NO. 72 08406	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2788		5. CITY OR TOWN C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX F 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 8-9-16 9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse	
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John B. Hill	
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 53 218-2672	
17. INFORMANT John Butler 4002 Belvoir Ave				18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST		15 min	
ANTECEDENT CAUSES				(B) DISSECTING AORTIC ANEURYSM DUE TO, OR AS A CONSEQUENCE OF:		2 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 8-29-72				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POOR		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-29-72 to 9-1-72 that (I) (we) last saw the deceased alive on 9-1-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Laborer Mural				23B. DATE SIGNED 9-1-72		23C. PHYSICIAN'S NAME (Type) SAHASCHAI MUSIKABHUMHA	
23D. ADDRESS SINAI HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-5-72	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary				24D. LOCATION (City, town, or county) (State) Balto Md Maryland		25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972	
25B. NAME OF REGISTRAR Sidney Whitton				25C. FUNERAL DIRECTOR U. Brooks Ruggold		ADDRESS 1463 N. Carey St	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-200		72 08407		BALTIMORE CITY HEALTH DEPARTMENT		72 08407	
BIRTH NO.				STATE OF MARYLAND - DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HICKS, John				August 31, 1972 XX 11:45P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Veterans Administration Hospital				Maryland			
3900 Loch Raven Blvd				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
Baltimore, Maryland 21218				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				2036 E. Lenvale Street			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/25/09	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)	
Crane operator		Bethlehem Steel Co.		Virginia		63	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
Henry Hicks				U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
yes				211-28-42 12-15-44 213-09-4234		Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				14. MOTHER'S MAIDEN NAME			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Ida Thornton			
ANTECEDENT CAUSES				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				yes			
II				18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				19. DATE OF OPERATION			
collo-cutaneous fistula				07/28/72			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
07/28/72				intestinal obstruction			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (X) (this hospital) attended the deceased from July 19, 1972 to August 31, 1972, that (X) (we) last saw the deceased alive on August 31, 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Richard F. Kieffer, Jr., M.D.				9/1/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
RICHARD F. KIEFFER, JR., M.D.				3900 Loch Raven Blvd Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-5-72		Arbutus MEMORIAL PARK		Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 5 1972		Audrey Whitton		Gabriel B. Sengco		1412 E. Preston St.	

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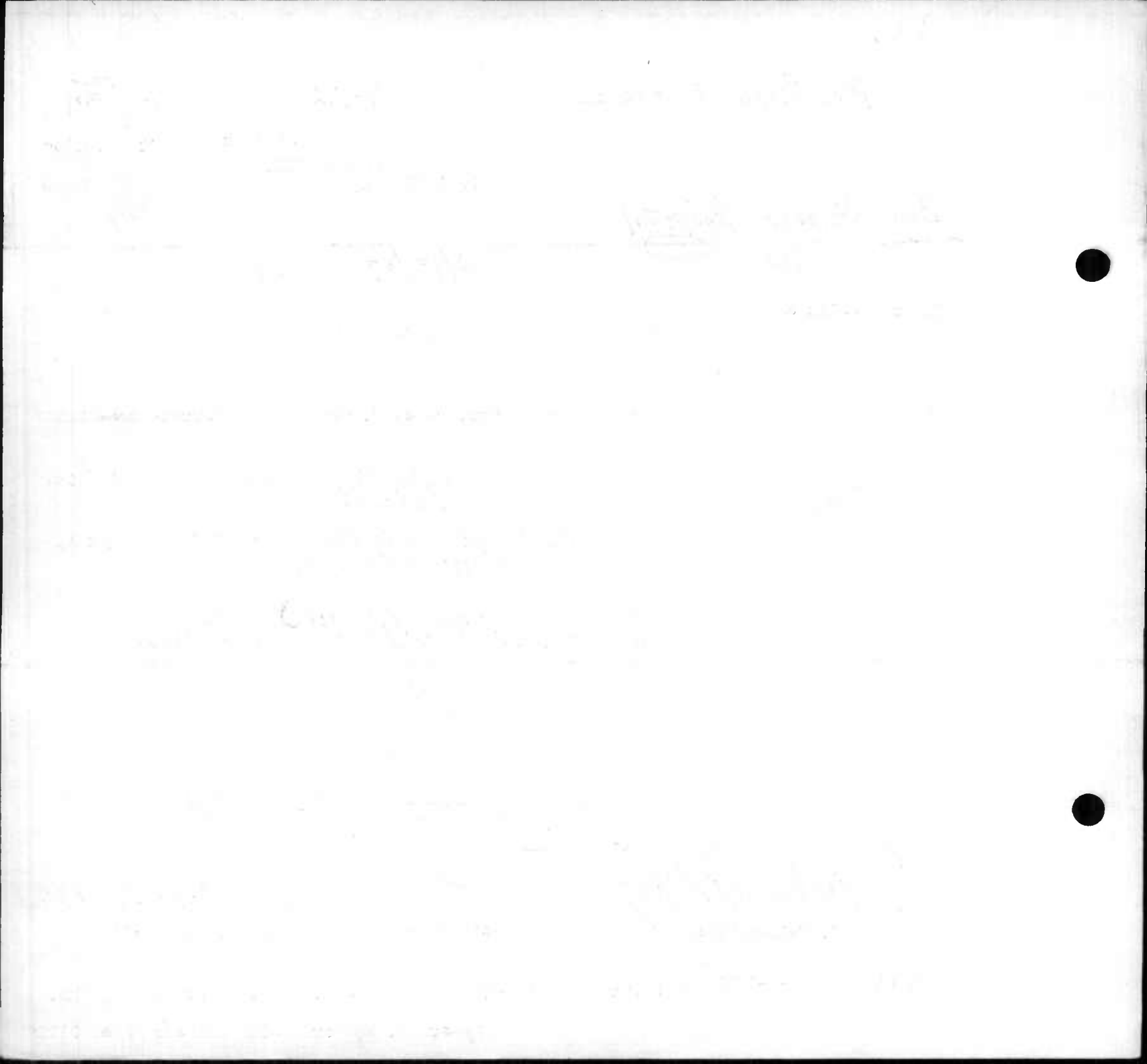
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-320		72 08408		BALTIMORE CITY HEALTH DEPARTMENT		72 08408	
<b>CERTIFICATE OF DEATH</b>				REG. NO. <u>STATE OF MARYLAND - DISTRICT</u>			
1. NAME OF DECEASED (Type or Print) <u>Mr. Frank E. Goetz</u>				2. DATE AND HOUR OF DEATH <u>9/2/72</u> <u>12 35 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>CATONSVILLE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1454 Barrett Rd.</u> <u>21207</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/13/09</u>	9. AGE (In years last birthday) <u>63</u>	10. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Louis Goetz</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Riley</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-09-2339</u>		17. INFORMANT <u>Mrs. Helen T. Goetz, 1454 Barrett Road 21207</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <u>Acute Myocardial Infarct</u> (B) <u>ASHD w. diffuse fibrosis of myocardium.</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hydrophilic Bladder, Diabetes Mellitus</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> 19 <u>72</u> to <u>Sept 2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Sept 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Nelson McKay</u>				23B. DATE SIGNED <u>Sept 2, 1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>J. Nelson McKay</u>				23D. ADDRESS <u>6014 Edmondson Ave., Balto., Md. 21228</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-5-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Wash. Blvd. Howard County, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			





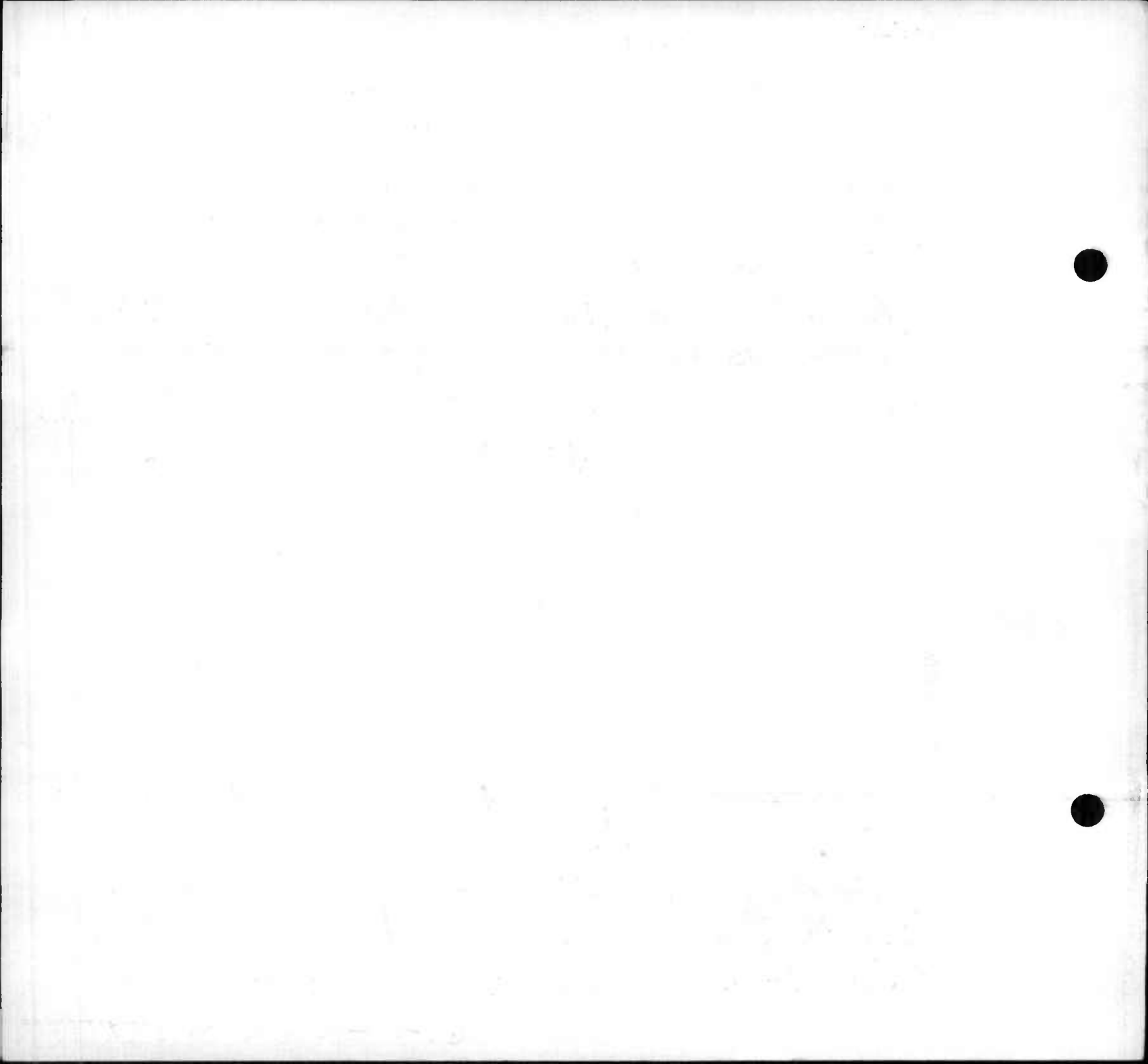
1. NAME OF DECEASED (Type or Print) (ALSO) LOREREA M. HARRINGTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3704 Chestle Place		3. DATE PRONOUNCED DEAD		9	3	1972	12:33p M.
6. SEX female		7. RACE white		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 8-18-1924		10. AGE (In years last birthday) 48		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME William Marshall		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Minnie Richardson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 296-20-8257		18. INFORMANT Barnett Funeral Home, 332 N. Main St.		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no		22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. HOW DID INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
23. ACTUAL SIGNATURE Marvin S. Platt, M.D.		23. DATE SIGNED 9-4-72		23. NAME OF REGISTRAR Sidney Harrison		23. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-6-1972		24C. NAME OF CEMETERY or CREMATORY Slomp Cemetery		24D. LOCATION (City, town, or county) (State) Smith County, Virginia	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR Sidney Harrison		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25D. ADDRESS	

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

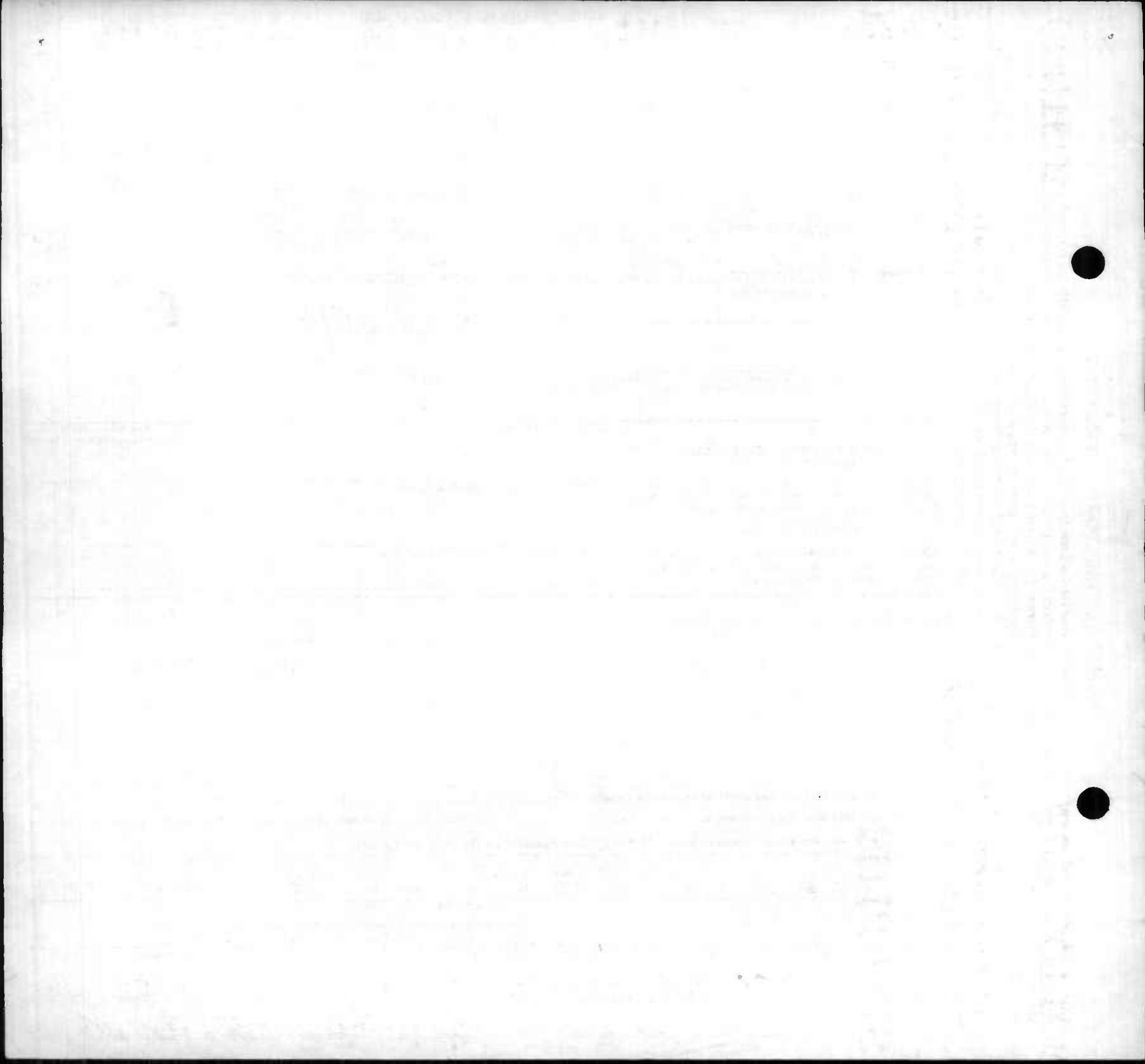
S-300		72 18410		BALTIMORE CITY HEALTH DEPARTMENT		72 08410	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Schade Edith</i>				2. DATE AND HOUR OF DEATH <i>Aug 31 1972</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harford Gardens Nursing Home</i> <i>4700 Harford Road</i>				A. STATE <i>MD</i> B. COUNTY <i>BALTO</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2902 Somerset Ave</i>							
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/27/82</i>	
9. AGE (In years last birthday) <i>90</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Reynolds Colein</i>				14. MOTHER'S MAIDEN NAME <i>Alexia A Floyd</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-48-2634</i>		17. INFORMANT <i>Edith C Kuemmer</i>			
18. <i>412.4 I</i>		CAUSE OF DEATH <i>ASCVD</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:		(D) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 17</i> 19 <i>72</i> to <i>Aug 31</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>Aug 17</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.							
23A. SIGNATURE <i>Lay M. Zimmerman M.D.</i>				23B. DATE SIGNED <i>8/31/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>Lay M. Zimmerman M.D.</i>				23D. ADDRESS <i>3202 Harford Rd. Baltimore, MD</i>			
24A. BURIAL-CREATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>9/4/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Louisa Park</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 5 1972</i>		25B. NAME OF REGISTRAR <i>Andrew Whitton</i>		25C. FUNERAL DIRECTOR <i>C.F. Evans &amp; Son</i>			
25D. ADDRESS <i>8502 Harford Rd. Baltimore, Md.</i>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08411	
W-300 72 08411				CERTIFICATE OF DEATH	
BIRTH NO.				STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) Margaret White			2. DATE AND HOUR OF DEATH Aug 16, 1972 4:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City 1603 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1607 B Riggs Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/00	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) JOPPA MD	
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME Issac Wilman		
14. MOTHER'S MAIDEN NAME Ida Mae Jones			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		
16. SOCIAL SECURITY NO. 219 10 3191		17. INFORMANT Chart ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebrovascular accident (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 6 1972 to Aug 16 1972 that (I) last saw the deceased alive on Aug 15 1972 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.					
23A. SIGNATURE Edward James Busick Jr MD DEGREE				23B. DATE SIGNED Aug 16, 1972	
23C. PHYSICIAN'S NAME (Type) Edward James Busick M.D. DEGREE				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 28-72		24C. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY	
24D. LOCATION JOPPA HA MD		24E. NAME OF REGISTRAR SEP 5 1972			
24F. DATE REC'D BY HEALTH DEPT.		24G. NAME OF REGISTRAR		24H. FUNERAL DIRECTOR ADDRESS GEORGE W TITTLE BEL AIR MD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-235		72 08412		BALTIMORE CITY HEALTH DEPARTMENT		72 08412	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		Elizabeth Coston				2. DATE AND HOUR OF DEATH Aug 30, 1972 3:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1501				C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pleasant Manor 90 Nursing Home		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 1506 Mountmor Ct.	
5. SEX F	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/85	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Wilkows		14. MOTHER'S MAIDEN NAME Augusta		Phone: 383-9253		ADDRESS 3016 Guyana Falls pkwy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-0827		17. INFORMANT Josephine De Lane		ADDRESS 3016 Guyana Falls pkwy	
18. 403X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Unemia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Nephrosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Arteriosclerosis		(B) DUE TO, OR AS A CONSEQUENCE OF: Hemiparesis, early, 2 days				(C) DUE TO, OR AS A CONSEQUENCE OF: Unkown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		21G. DATE SIGNED 8/30/72		21H. DATE SIGNED 8/30/72	
22. I certify that (I) (this hospital) attended the deceased from Nov. 1970 to 8/30 1972, that (I) (we) last saw the deceased alive on 8/30 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE D. W. STEWART, M.D.				23B. DATE SIGNED 8/30/72		23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/2/72		24C. NAME OF CEMETERY OR CREMATORY Arboretus Memorial Park		24D. LOCATION (City, town, or county) (State) Arboretus Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR Henry Wilkows		25C. FUNERAL DIRECTOR Wilkows Funeral Home		ADDRESS 3198 Belvidere St.	



OFFICE

FILE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHESTER BARKER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL 10-13-72</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 2, 1972 1:58 A.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <b>Maryland</b> B. COUNTY <b>1902</b>							
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>1/28/1928</b>		10. AGE (In years last birthday) <b>44</b>		E. STREET AND NUMBER <b>320 S. Parish Parrish St. 21223</b>			
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Andrew Barker</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Omaha Steel Works</b>		15. MOTHER'S MAIDEN NAME <b>Lena Hackworth</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>506-24-6833</b>		18. INFORMANT <b>Deleen T. Barker</b>		ADDRESS <b>227 S. Fulton Ave. 21223</b>	
19. CAUSE OF DEATH <b>412.4 + 303.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute alcoholic intoxication</b> <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Acute alcoholic intoxication</b>							
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> M.D. EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>9/5/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Dr. J. J. [illegible]</b>		25C. FUNERAL DIRECTOR <b>John J. Gowan, Inc.</b>		ADDRESS <b>901 Hallens St. Balto. Md. 21223</b>	

10-13-1972 - Letter from the Office of the Chief Medical Examiner,  
Peter Lipkovic, M.D., Assistant Medical Examiner HS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08414	
W-452				72 08414			
BIRTH NO.				72 08414			
1. NAME OF DECEASED (Type or Print) <b>Laura Williams</b>				2. DATE AND HOUR OF DEATH <b>8-31-72 2:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital, Inc.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1102</b>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/24/1882</b>	
9. AGE (In years last birthday) <b>90</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Laura Jackson</b> ADDRESS <b>1714 Red Oak Rd. Balto., Md. 21234</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Renal Failure</b> <b>Severe Dehydration</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVD, Diabetes Mellitus, Pneumonia</b>			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>8-27</b> 19 <b>72</b> to <b>8-31</b> 19 <b>72</b> , that (X) (we) last saw the deceased alive on <b>8-31</b> 19 <b>72</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.							
23A. SIGNATURE <b>John E. Seibel, Jr., MD</b>				23B. DATE SIGNED <b>8/31/72</b>		23C. PHYSICIAN'S NAME (Type) <b>John E. Seibel, Jr., MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>9/2/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>2930 Frederick Ave. Balto,</b>				25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney W. Horton</b>				25C. FUNERAL DIRECTOR <b>Edw. S. MacNabb Sons, Inc.</b>			
25D. ADDRESS <b>301 Frederick Rd. Catonsville, Md.</b>				25E. ADDRESS <b>301 Frederick Rd. Catonsville, Md.</b>			

6/8/67 - Adm. Midtown N. H.

1/24/1968

Unknown

Frederick Sparks

Homeville

Mrs. Laura Jackson

2930 Frederick Ave. Suite 201

Frederick, Md. 21701

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08415	
T-150 72 08415 CERTIFICATE OF DEATH				REG. NO. 72 08415 STATE OF MARYLAND-DHMH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John. E. Tobin		8/31/72 10 <sup>00</sup> P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Gould Convelisarium			Md.		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3446 Hickory Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/31/92	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Crane Oiler		Local 37		Va.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
?			U.S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		227-09-5419		Helen M. Tobin (same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Recurrent Rheumatism & Urinary Tract Infection weeks		
			(B) DUE TO, OR AS A CONSEQUENCE OF: Cachexia months		
			(C) Anystrophic Latent Phosia > 1 yr.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10/9/1971 to 8/31/1972 that (I) (we) last saw the deceased alive on 8/27/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Albert B. Bradley, M.D.				9/1/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Albert B. Bradley, M.D.		4900 Belair Road 21206			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/2/72		Saters	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 5 1972		Sidney Johnson		Paul E. Chenoweth 3rd 3617 Chestnut Ave	

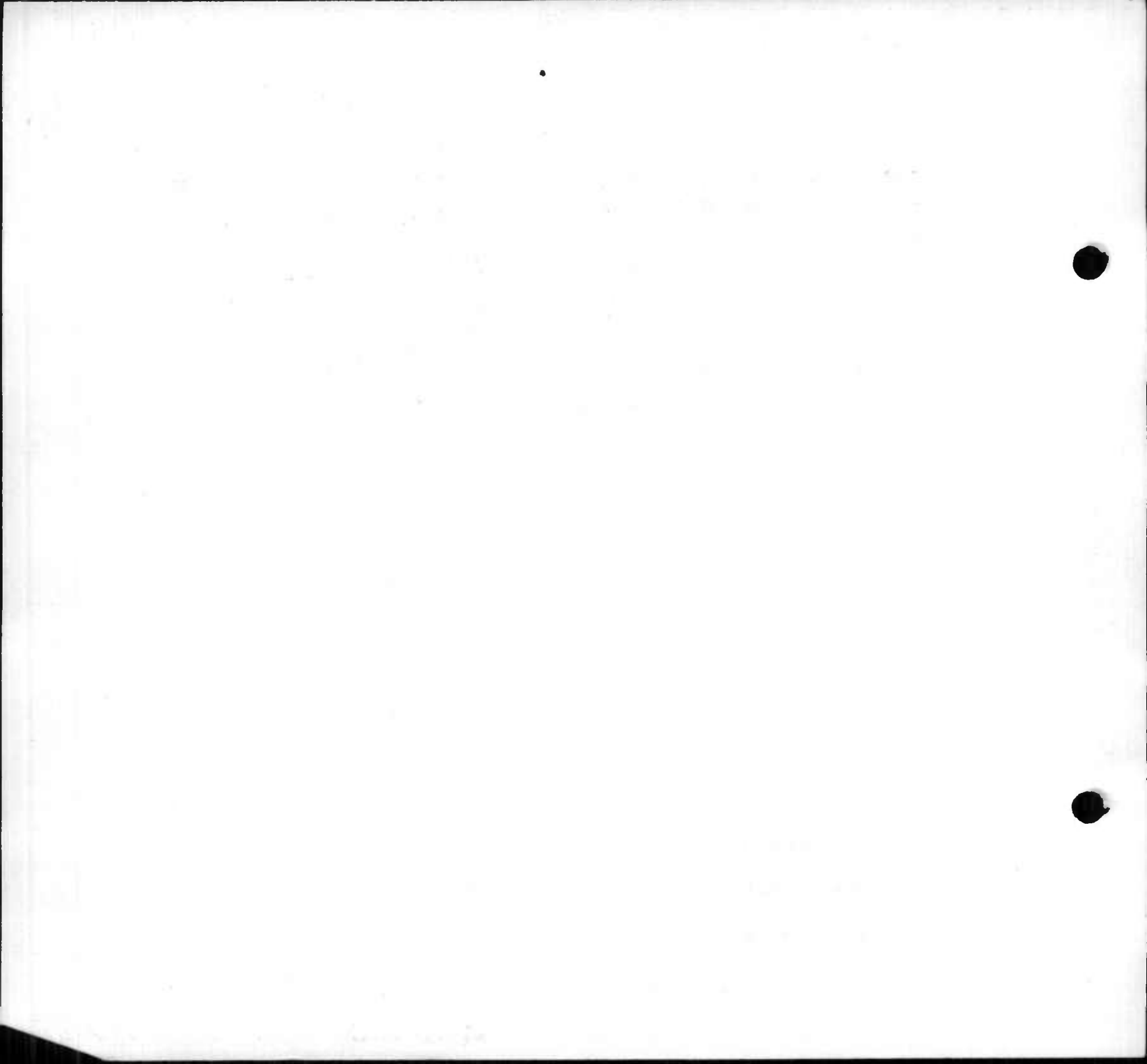




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>S-345</b>      <b>72 08416</b></p> <p>BIRTH NO.      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p><b>72 08416</b></p> <p>REG. NO.      <b>STATE OF MARYLAND - DUMM</b></p>	
<p>1. NAME OF DECEASED (Type or Print)      <b>Edna Stallings</b></p>		<p>2. DATE AND HOUR OF DEATH    <b>9-1-72</b>      <b>940 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION      (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><b>90</b>      <b>Century Home, Inc.</b> <b>102 N. Poca St. 21201</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE      <b>Md.</b>      B. COUNTY      <b>2005</b></p> <p>C. CITY OR TOWN      <b>Baltimore</b>      D. INSIDE CITY LIMITS?      YES <input checked="" type="checkbox"/>      NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER      <b>339 S. Smallwood St.</b></p>	
<p>5. SEX      <b>F</b></p>	<p>6. RACE      <b>W</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH      <b>8/1/85</b></p>
<p>9. AGE (In years last birthday)      <b>87</b></p>		<p>If Under 1 Yr.      If Under 24 Hrs.      If Under 24 Hrs.      Min.</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)      <b>Retired</b></p>
<p>11. BIRTHPLACE (State or foreign country)      <b>Baltimore, Md.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?      <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME      <b>Mr. Geo. E. Houck</b></p>		<p>14. MOTHER'S MAIDEN NAME      <b>Fannie Rhine</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)      <b>No</b></p>		<p>16. SOCIAL SECURITY NO.      <b>218260717</b></p>	<p>17. INFORMANT      <b>Mrs. Zimmerman Balto.</b>      ADDRESS      <b>200 Choptank Ave. 1071287</b></p>
<p>18. <b>41241</b>      CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH      <b>Cardio-Respiratory Failure</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES      <b>(A) IMMEDIATE CAUSE</b> <b>Due to, or as a consequence of:</b> <b>Arteriosclerotic CVD</b> <b>Gen + Cerebral Arteriosclerosis</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Anemia - etiology (?)</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.      <b>Senility</b></p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION      <b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)      <b>No</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)      <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR?      (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Approx.)      (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED      While At Work <input type="checkbox"/>      Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Aug 9</b> 19<b>72</b> to <b>Sept 1</b> 19<b>72</b> that (I) (we) last saw the deceased alive on <b>19</b> and that (in my) <b>(not)</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We <del>did</del>) (did not) view the body after death.</p>			
<p>23A. SIGNATURE      <b>William Boncetero</b>      DEGREE</p>		<p>23B. DATE SIGNED      <b>Sept 1, 1972</b></p>	
<p>23C. PHYSICIAN'S NAME (Type)      <b>William Boncetero</b>      DEGREE</p>		<p>23D. ADDRESS      <b>6615 Neustaten Rd</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)      <b>Burial</b></p>		<p>24B. DATE      <b>9/5/72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY      <b>Woodlawn Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State)      <b>Woodlawn, Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.      <b>SEP 5 1972</b></p>		<p>25B. NAME OF REGISTRAR      <b>Lidny Whiston</b></p>	
<p>25C. FUNERAL DIRECTOR      <b>W. J. Whiston, Inc.</b>      ADDRESS      <b>6101 Frederick Rd. Balto. Md.</b></p>		<p>VS 150-REV. 1/7/68</p>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08417

BIRTH NO.

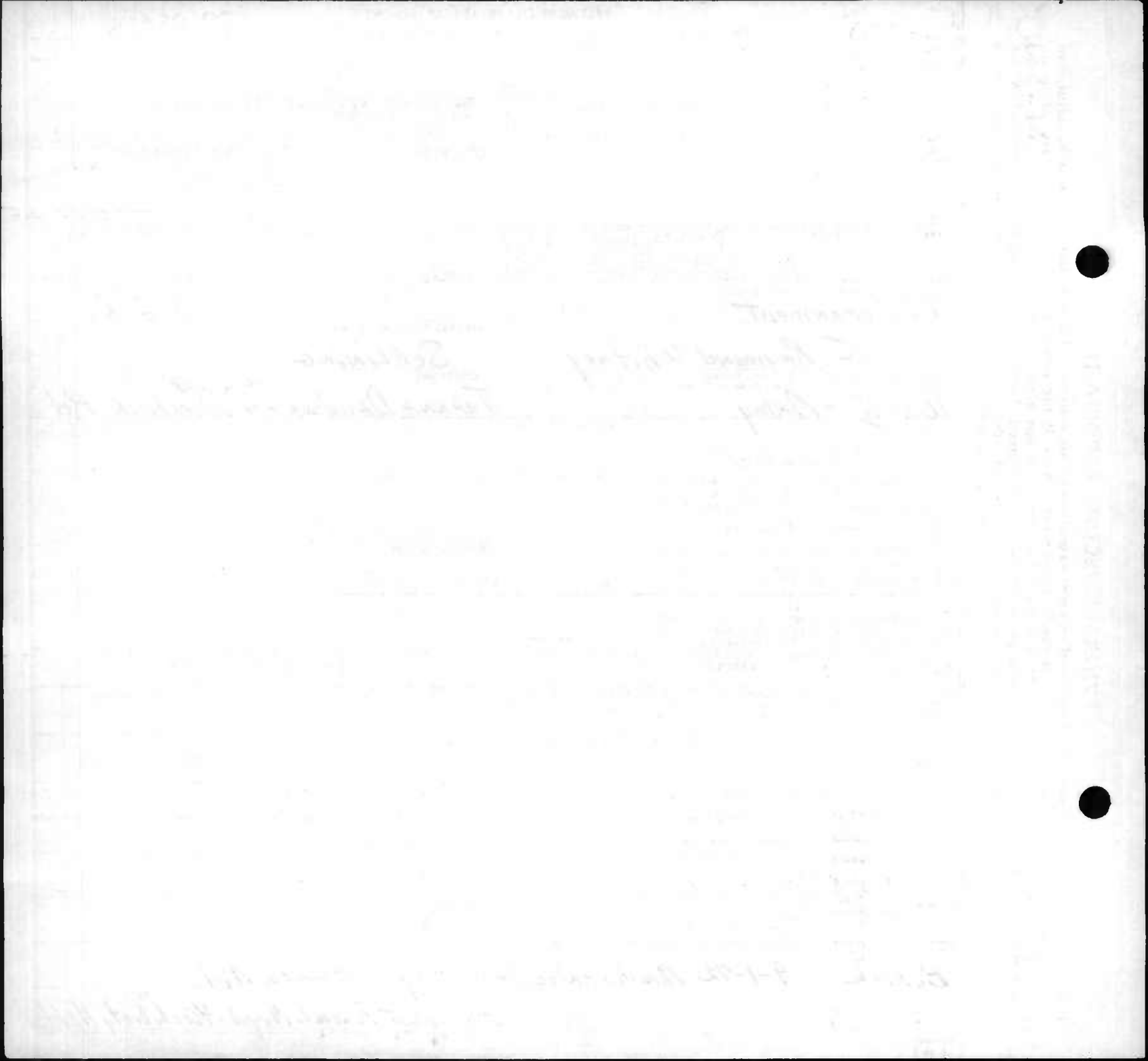
1. NAME OF DECEASED (Type or Print) EARL A. HAYES, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Rear of 1129 N. Bentalou		3. DATE PRONOUNCED DEAD Month Day Year Hour September 1, 1972 1:50 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 6/17/31		10. AGE (In years last birthday) 41	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Earl A Hayes, Sr		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2037	
15. MOTHER'S MAIDEN NAME		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 2		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs Ella Mae Toliver, Same		ADDRESS	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 9/2/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/7/72	
24C. NAME of CEMETERY or CREMATORY MT Auburn Cemetry		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

*Handwritten signature*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08418</b>
<b>W-350</b> BIRTH NO. <b>72 08418</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Whitney, Noble A.</b>		2. DATE AND HOUR OF DEATH <b>8/29/72 155 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GEN. HOSP.</b> <b>48</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2841</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3808 Gwynn Oak Ave</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02-27-09</b>	9. AGE in years (last birthday) <b>63</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Government</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>G. Raymond Whitney</b>		
14. MOTHER'S MAIDEN NAME <b>Schlining</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes, U.S. Army</b>		
16. SOCIAL SECURITY NO. <b>218-22-0225</b>		17. INFORMANT <b>Joanna Davidson - #21228</b>		
18. <b>435-X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Renal Failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Constrictive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Primary Myocardopathy</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic</b> <b>Chronic</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>± 2 weeks</b>		
<b>II</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <b>8/18/72</b> to <b>8/29/72</b> that (1) (we) last saw the deceased alive on <b>8/29/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>A. Brucker M.D.</b>		23B. DATE SIGNED <b>8/29/72</b>		23C. PHYSICIAN'S NAME (Type) <b>A. BRUCKER M.D.</b>
23D. ADDRESS <b>MD. GEN. HOSP.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>9-1-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Dr. J. H. Wilson</b>		25C. FUNERAL DIRECTOR <b>ARMACOST Funeral Chapel - 4600 Liberty Heights</b>

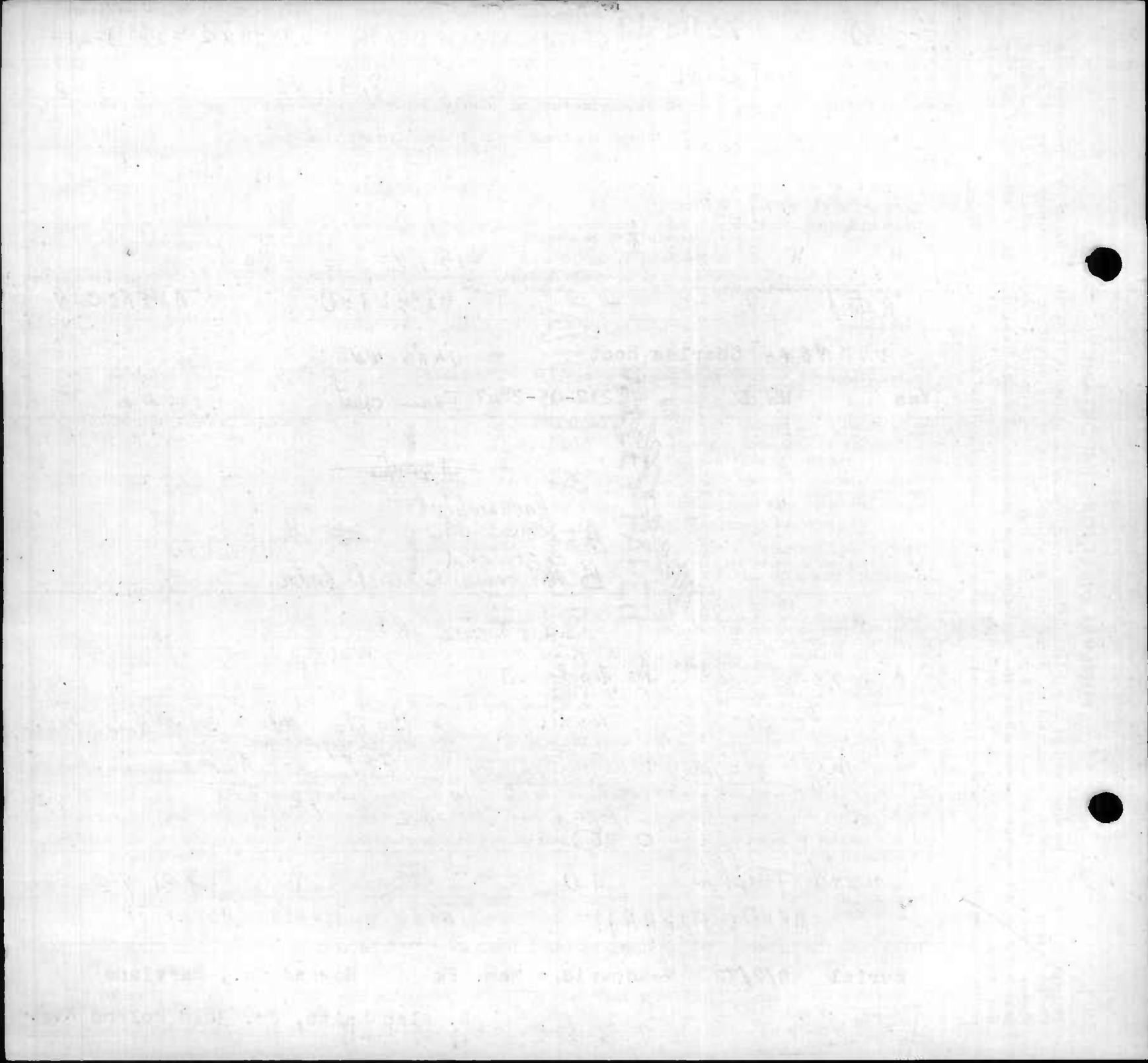


# FUNERAL DIRECTOR: IMPORTANT

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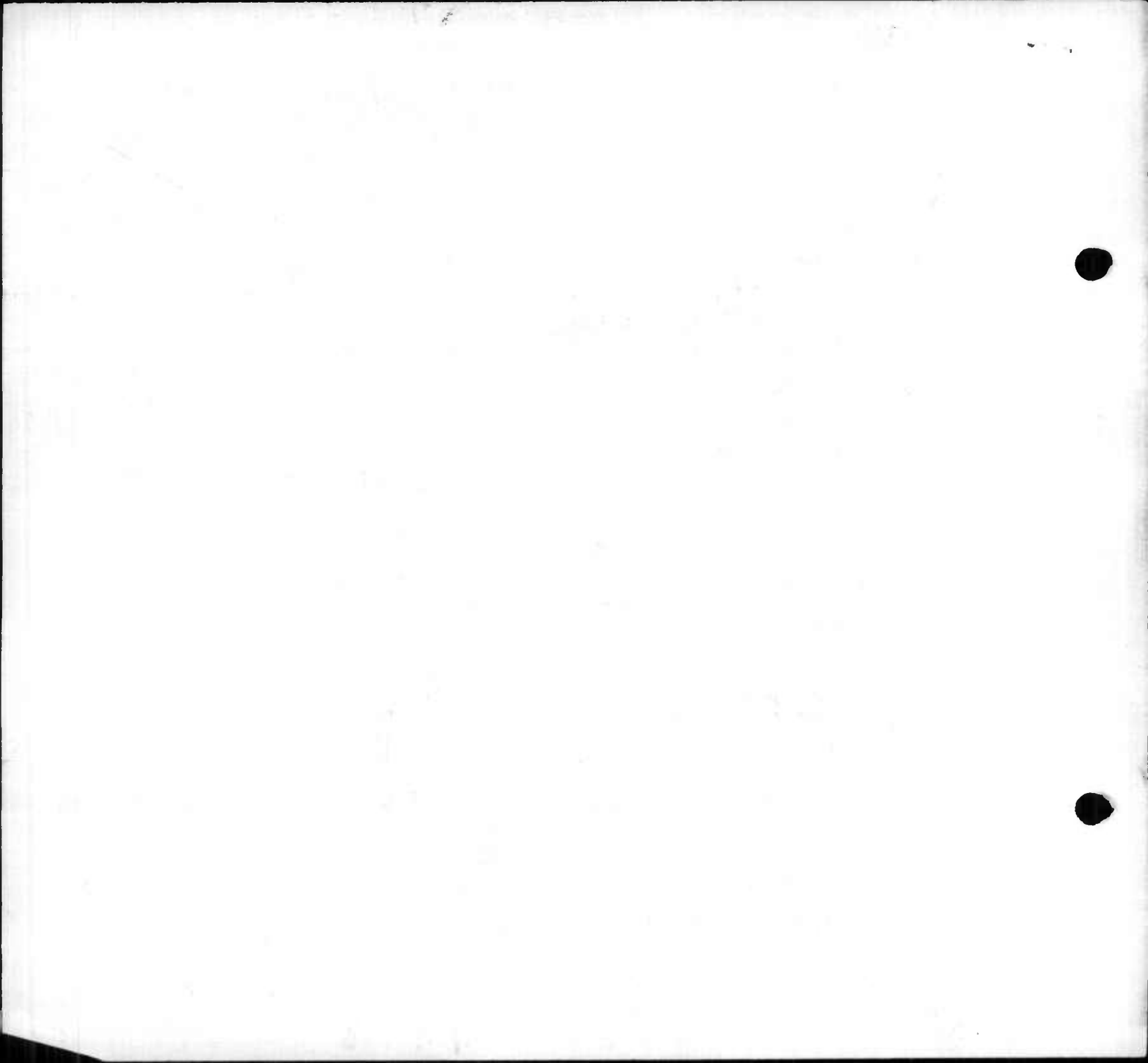
BIRTH NO. <b>H-300</b>		72 08419		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08419</b>	
1. NAME OF DECEASED (Type or Print) <b>HOOT CARL F.</b>				2. DATE AND HOUR OF DEATH <b>8, 31, 72</b> <b>12:15 P.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3378 S. CALVERT STREET</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>1307</b>	
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2, 5, 92</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		9. AGE (In years last birthday) <b>80</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>UNKNOWN Charles Hoot</b>				12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>212-05-2847</b>		17. INFORMANT <b>From chart</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
A. IMMEDIATE CAUSE <b>Pneumonia</b>							
B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if giving rise to the above cause (A) calling for UNDERLYING CONDITION lost. <b>Septicemia</b>							
C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>hip Fracture RT</b>							
19A. DATE OF OPERATION <b>8, 14, 72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>hip fracture RT</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? <b>Ba Ho., Md. 3439 Roland Ave.</b>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>Aug 9, 1972 11:30 PM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fall at home.</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>8, 10</b> to <b>8, 31</b> and that (I) (we) last saw the deceased alive on <b>8, 31</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Mehdi Fakhr</b> M.D.				23B. DATE SIGNED <b>8, 31, 72</b>		23C. PHYSICIAN'S NAME (Type) <b>MEHDI FAKHRAI</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/2/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Adrian J. Hoot</b>		25C. FUNERAL DIRECTOR <b>A. Alan Seitz, Jr.</b>		ADDRESS <b>3818 Roland Ave.</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-540		72 08420		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08420	
BIRTH NO.				STATE OF MARYLAND-DEATH			
1. NAME OF DECEASED (Type or Print) CONNELLY, Mr. PATRIEK S.				2. DATE AND HOUR OF DEATH 8/29/72 9-45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY 2610			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital 5 Baltimore. Md. 21231				C. CITY OR TOWN BALT		D. (INSIDE CITY LIMITS?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 434 N HIGHLAND AVE 21224							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-03	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired SHAUFFER		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? AMER	
13. FATHER'S NAME COLEMAN CONNELLY				14. MOTHER'S MAIDEN NAME MARYELLEN WALSH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213 03 5121		17. INFORMANT JOSEPHINE CONNELLY	
18. 4124 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Due to, or as a consequence of: Coronary pulmonary		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mts	
				(B) overexert - → progressive Due to, or as a consequence of:		- 1 wk	
				(C) Congestive failure. ASCVD. cigarette.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/4/1972 to 8/29/1972 that (I) (we) last saw the deceased alive on 8/29/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. Padmaraju				23B. DATE SIGNED 8/29/72			
23C. PHYSICIAN'S NAME (Type) L. PADMARAJU, M.D.				23D. ADDRESS Church Home & Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9/2/72		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR Andrew Johnston		25C. FUNERAL DIRECTOR John A. Moran, Inc. ADDRESS 3000 E. Baltimore St. Baltimore, Md. 21224			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08421	
L-520 72 08421				STATE OF MARYLAND-DMH	
BIRTH NO.			72 08421		
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
LYONS, Clara M.			3:39 8/30/72 3:39 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			Maryland		
The Johns Hopkins Hospital			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			223 N. Maderia Street		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/1/08	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Store Clerk			Maryland		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas J. Oliff			Mary Scates		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			yes		Mr. William V. Lyons 223 N. Maderia St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cardiovascular collapse 5 min		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Cardiopulmonary arrest & resuscitated 10 hours		
			(C) Probable breast carcinoma (R) 2 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/24 19 72 to 8/30 19 72, that (I) (we) last saw the deceased alive on 8/30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Kenneth L. Baughman, M.D.				8/30/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Kenneth L. Baughman, M.D.				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		9/1/72		Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 5 1972		John A. Moran, Inc.		3000 E. Baltimore St. Baltimore, Md. 21224	



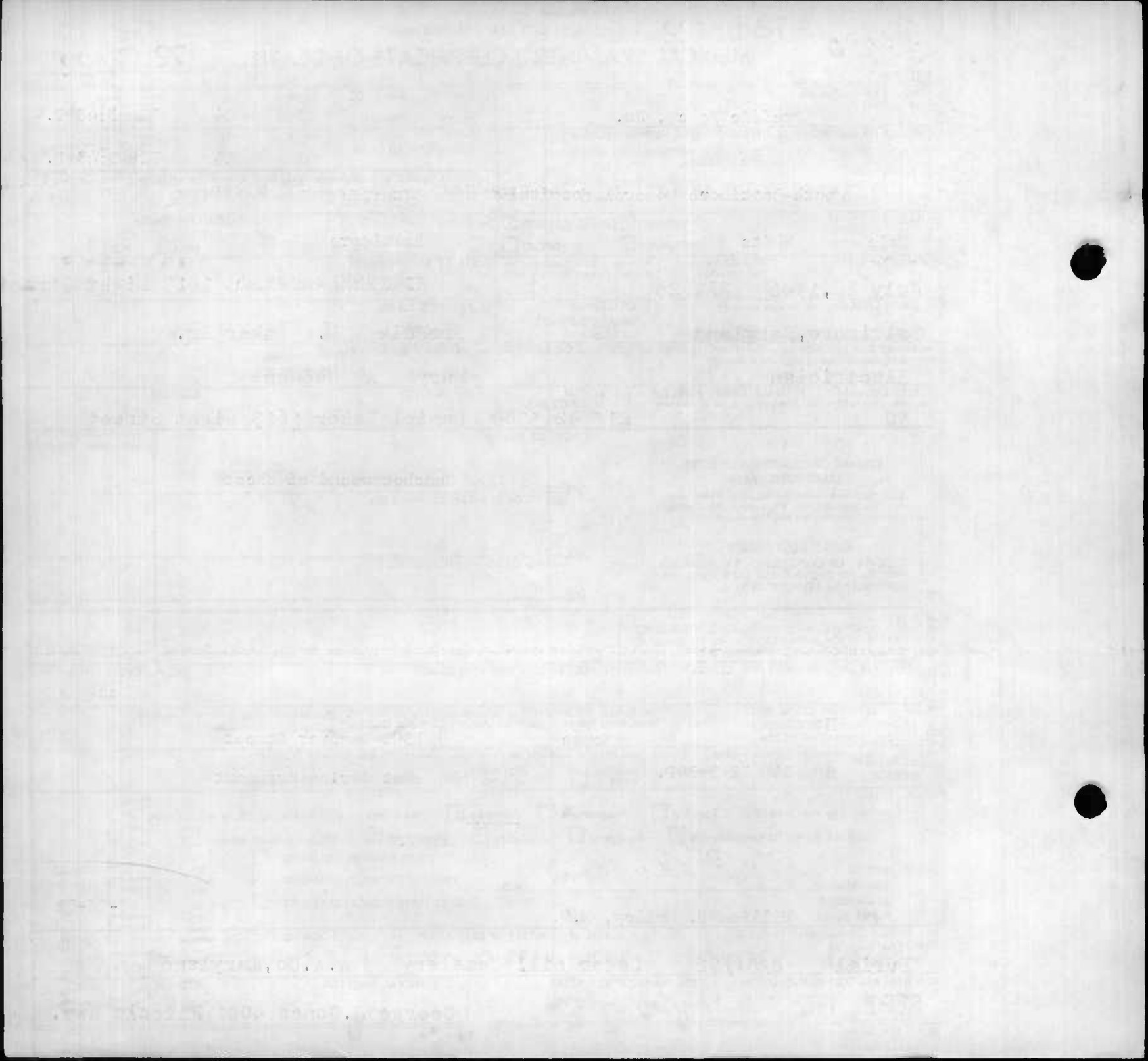
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08422

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Freddie L Baker, Jr.</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>8 24 72 3:48 P. M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Baltimore General Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>8 24 72 3:48 P. M.</b>			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2404</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>XXXXXX XXXXX XXXXX 1613 Light Street</b>			
9. DATE OF BIRTH <b>July 28, 1946</b>		10. AGE (In years last birthday) <b>XXX 26</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				13. FATHER'S NAME <b>Freddie L. Baker Sr.</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME <b>Mary A Redman</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
17. SOCIAL SECURITY NO. <b>215 42 5309</b>				18. INFORMANT ADDRESS <b>Daniel Baker 1613 Light Street</b>			
19. CAUSE OF DEATH <b>2965 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of chest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>Yes</b>				22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <b>22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House</b>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1300 Hanover Street</b>				22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>8 24 72 3:30 P. M.</b>			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>shot during argument</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>W.P. Mulloy</b> M.D. EXAMINER'S NAME (Type) <b>William P. Mulloy, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>8-25-72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8/31/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A.Co, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Adrian S. [Signature]</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George J. Gonce 4001 Ritchie Hwy.</b>			

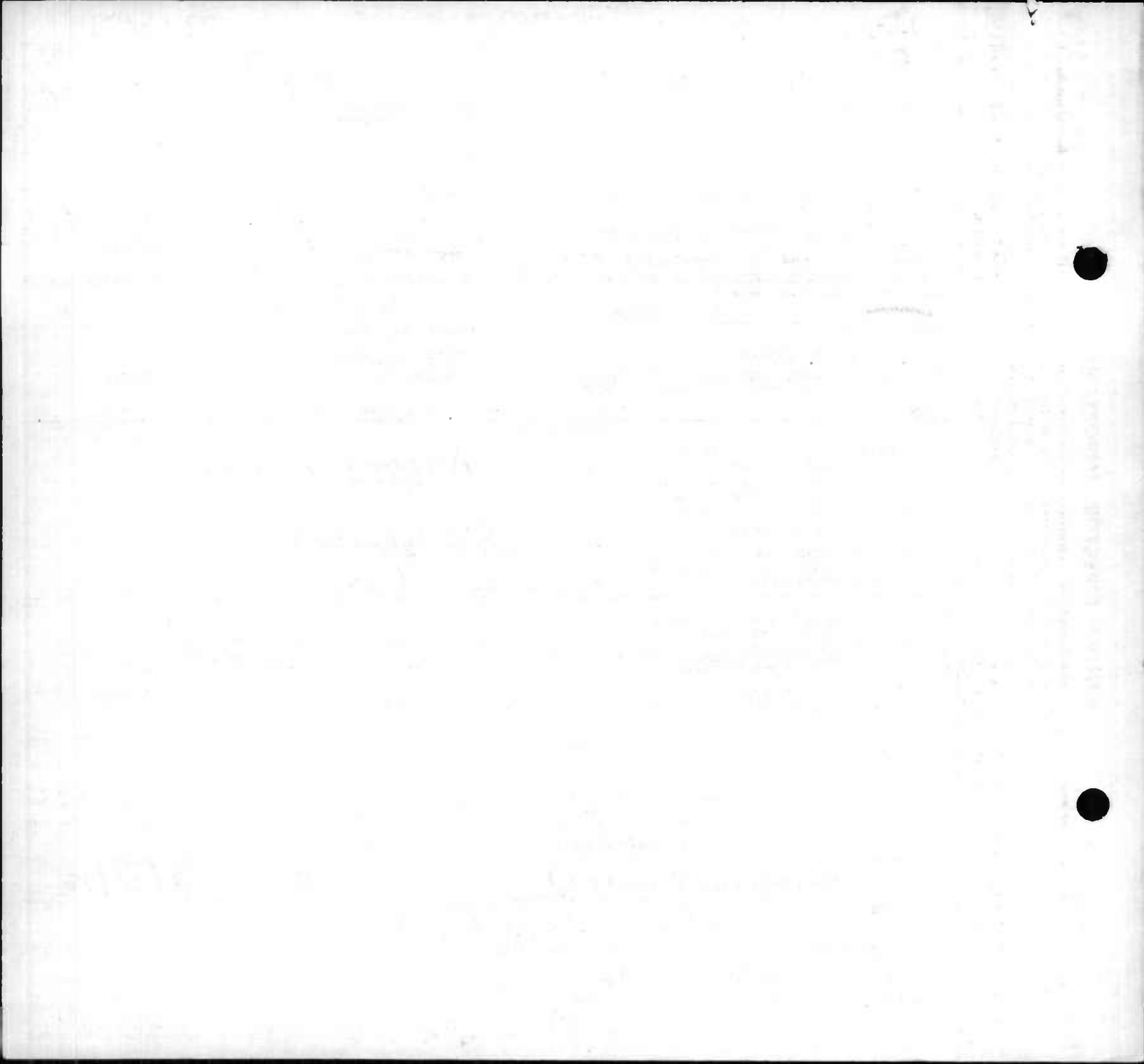




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08423	
W-500 72 08423				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Wann, Mabel Jo.</u>		2. DATE AND HOUR OF DEATH <u>8/31/72 10:20 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>8 Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1123 Ramblewood Rd. apt. A</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/1901</u>		9. AGE (In years last birthday) <u>71</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Clarence M. Lloyd</u>		
14. MOTHER'S MAIDEN NAME <u>Edith Wheeler</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>220-52-6266</u>			17. INFORMANT <u>Mr. Charles Lloyd Bradshaw &amp; Hillside Rd.</u>		
18. CAUSE OF DEATH <u>427.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Aspiration of vomit</u> <u>Pulmonary oedema</u> <u>Congestive heart Fail</u>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> 19 <u>72</u> to <u>8/31</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/31</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hyo-yun Yun M.D.</u>				23B. DATE SIGNED <u>8/31/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Hyo-yun Yun M.D.</u>				23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9/5/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>		25B. NAME OF REGISTRAR <u>Richard H. Wooten</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7101 Belair Road</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 08424</span>				72 08424 CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 08424</span>	
1. NAME OF DECEASED (Type or Print) <b>DOWNS, Clarence Clarence</b>				2. DATE AND HOUR OF DEATH <b>8/27/72</b> <span style="float: right;">6 A M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b> Md. </b> B. COUNTY <b> U.S.A </b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>1425 Morling Ave.</b>		<b>21211</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> <del>WIDOWED</del> <input type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/09</b>	9. AGE (In years last birthday) <b>63</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Langenfelser Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>UNKNOWN, James Downs</b>				14. MOTHER'S MAIDEN NAME <b>unknown.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No - - -</b>		16. SOCIAL SECURITY NO. <b>217-05-5497</b>		17. INFORMANT ADDRESS <b>Bennett Downs-831 Wellington St. 21211</b>			
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE <b>Cardiac-Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF:							
(B) <b>Undifferentiated Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF:							
(C) <b>of left lung.</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>26 8/26/1972</b> to <b>8/27 1972</b> that (I) (we) last saw the deceased alive on <b>8/27 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. Shocack</b>				23B. DATE SIGNED <b>17.D. DEGREE</b>			
23C. PHYSICIAN'S NAME (Type) <b>MAWYA SHOCACK</b>				23D. ADDRESS <b>MD Union Memorial Hospital Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/2/72</b>		24C. NAME of CEMETERY or CREMATORY <b>May's Chapel Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>				25B. NAME OF REGISTRAR <b>Alan Seitz, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3818 Roland Ave.</b>	

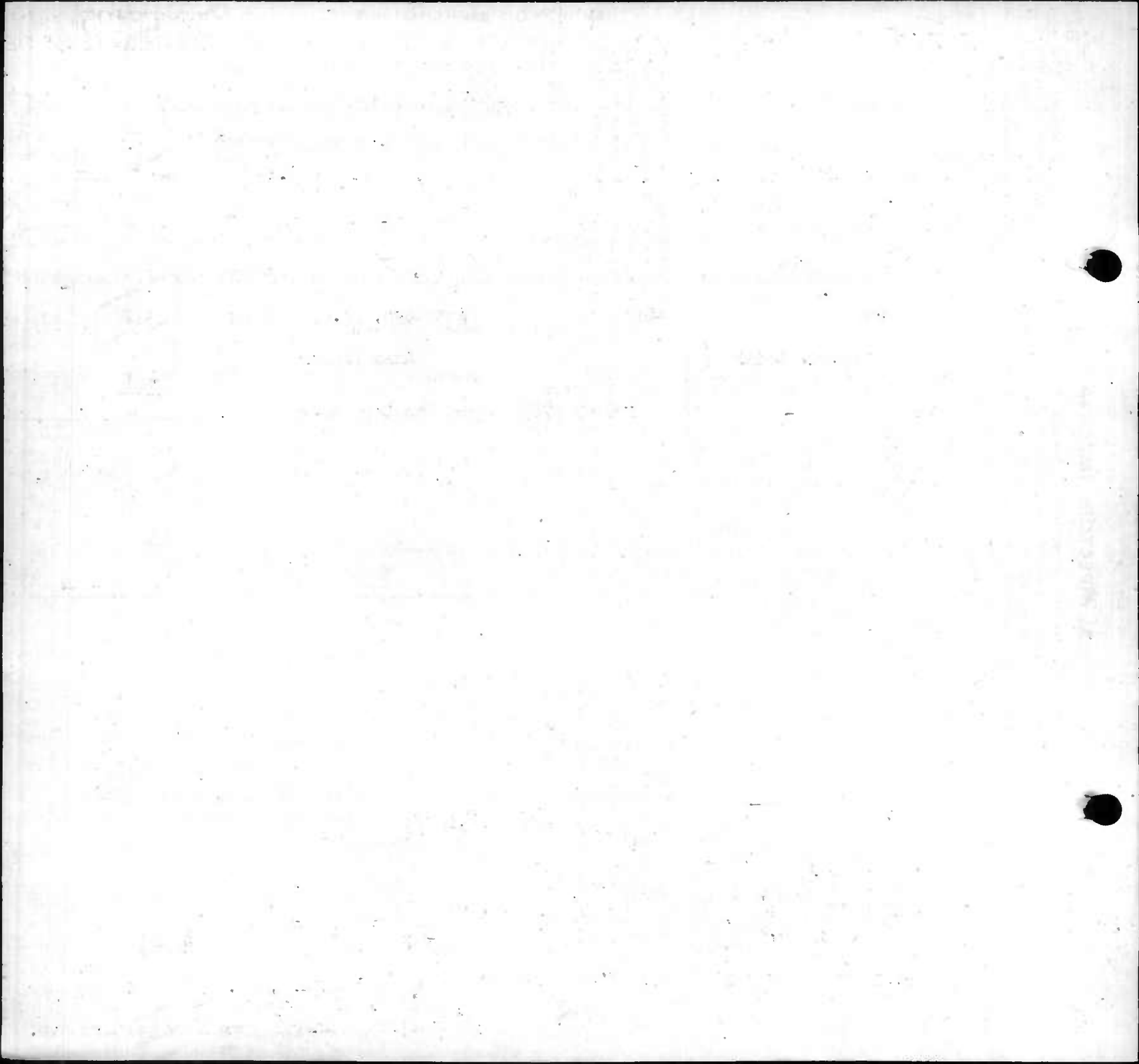
UP 11

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
72 08425 CERTIFICATE OF DEATH									
BIRTH NO. <span style="font-size: 1.5em;">7-523</span>					REG. NO. <span style="font-size: 1.5em;">72 08425</span>				
1. NAME OF DECEASED (Type or Print) <i>Fenstermacher, Margaret</i>					2. DATE AND HOUR OF DEATH <i>8-29-72 5:25 AM</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Hamilton Nursing Center</i> <i>6040 Hartford Rd.</i>					A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
					E. STREET AND NUMBER <i>507 Voght Lane</i>				
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-20-4</i>	9. AGE (In years last birthday) <i>68</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		11. BIRTHPLACE (State or foreign country) <i>Kutztown, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Nervin Smith</i>			14. MOTHER'S MAIDEN NAME <i>Anna Benner</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>196 03 9703</i>		17. INFORMANT <i>John Fenstermacher</i>				ADDRESS <i>Same</i>
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>pneumonia</i>					<i>1 week</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Senility</i>									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>8-29-72</i> to <i>8-29-72</i> , that (I) (we) last saw the deceased alive on <i>8-29-72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Wyman H. Wolk</i>					23B. DATE SIGNED <i>8-29-72</i>				
23C. PHYSICIAN'S NAME (Type) <i>Wyman H. Wolk</i>					23D. ADDRESS <i>6801 Belair Rd. Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/2/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Fair View Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Kutztown, Pa.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 5 1972</i>		25B. NAME OF REGISTRAR <i>Lidney</i>		25C. FUNERAL DIRECTOR <i>Brzezinski Funeral Home</i>		ADDRESS <i>1407 Eastern Ave.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08426		REG. NO.	
72 08426				72 08426		STATE OF MARYLAND	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		SIEPAIN CATHERINE L.		8-29-72 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
48 Md. General Hosp.				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				4509 WENDEL AVE.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.
ot	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9-19-92	79			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
housewife			at home		Md.		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Comegys				Louise Kurtz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no		213 094506		Esther Reid (sister) same as above			
18. 038.9 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio resp arrest			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: sepsis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) diabetes mellitus uremia acute suppurative emphysema			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
12-14-72		esoph. stenosis					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
1 Month) (Day) 1 Year) 1 Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from 8-6 1972 to 8-29 1972							
that (we) last saw the deceased alive on 8-29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
W H Bouchelle MD				8-29-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
William Bouchelle				MOH			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9/7/72		Parkwood Cemetery		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 5 1972				L. H. H. H. H.		Schimunek Funeral Homes, Inc. 3325 Backing Lane, Balto. Md. 21273	



4509 NEITZEL AVE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-420		72 08427		BALTIMORE CITY HEALTH DEPARTMENT		REC. NO. 72 08427	
BIRTH NO.				STATE OF MARYLAND - DEPT. OF HEALTH			
1. NAME OF DECEASED (Type or Print) <b>MONROE H. SCHLOSS</b>				2. DATE AND HOUR OF DEATH <b>AUGUST 30, 1972</b> <b>12:40 A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1201</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>HIGHFIELD HOUSE, APT. 1402</b> <b>4000 N. CHARLES STREET</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4000 N. CHARLES STREET, APT. 1402</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/19/1898</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANUFACTURING EXECUTIVE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JONAS SCHLOSS</b>				14. MOTHER'S MAIDEN NAME <b>RENEE HEINEMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES <input type="checkbox"/> W.W. I NAVY				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. SARAH SCHLOSS, 4000 N. CHARLES STREET,</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>284X1144X</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				CAUSE OF DEATH <b>1- Cardiovascular failure</b> <b>2- Atherosclerosis</b> <b>3- Squamous cell carcinoma b/lb floor mouth</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several months</b> <b>Op. Sep. 1971</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <b>Sep. 5</b> 1972 to <b>8/30</b> 1972, that (I) (we) last saw the deceased alive on <b>8/30</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Bernard Cohen MD</b>				23B. DATE SIGNED <b>8/30/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>BERNARD COHEN</b>				23D. ADDRESS <b>3501 ST. PAUL STREET</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>8/31/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Audrey Levinson</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 08428	
BIRTH NO. H-420 72 08428		STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>GUSSIE HEILIG</b>		2. DATE AND HOUR OF DEATH <b>8/30/72 5:45 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSP. OF BALT., INC</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>NEW YORK</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6603 Park Heights Ave</b> F. PARK AVENUE <b>7</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/94</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	9. AGE (In years last birthday) <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>CHICAGO, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? SHAPIRO</b>		14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>095-14-0279</b>	
17. INFORMANT <b>MRS. MARTIN L. STEIN</b>		ADDRESS <b>APT. A 2 6603 PARK HEIGHTS AVE.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROTIC HT. DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>8/28 1972</b> to <b>8/30 1972</b> that (H) (we) last saw the deceased alive on <b>8/30 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Dan Sunshine M.D.</b>		23B. DATE SIGNED <b>8/30/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAN SUNSHINE M.D.</b>		23D. ADDRESS <b>SINAI HOSP., BALT., MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL-BURIAL</b>		24B. DATE <b>8/31/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>WELLWOOD CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>FARMINGDALE, L.I., NEW YORK</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Sol Levinson</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERS TOWN ROAD</b>	

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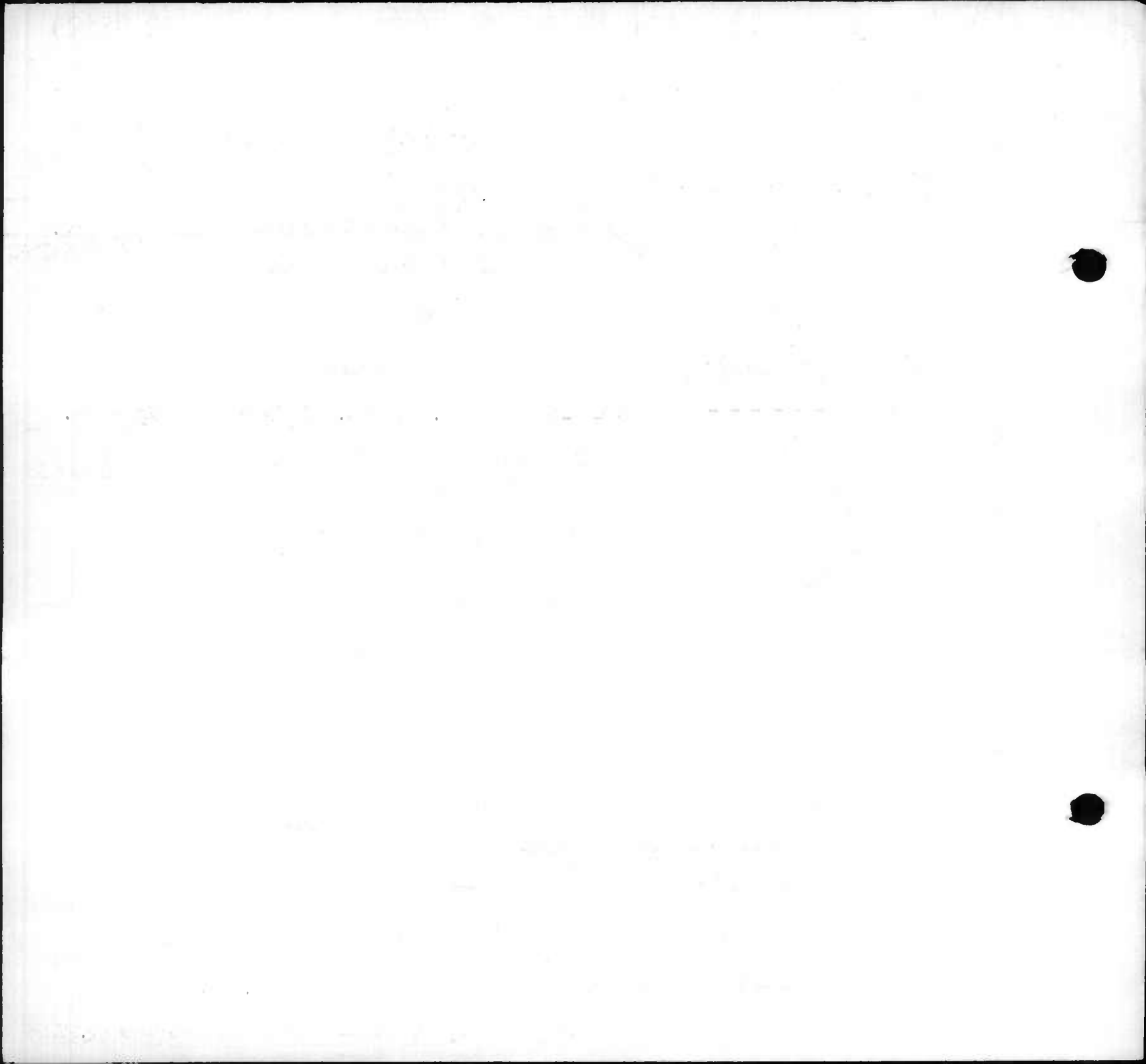
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-423		72 08429		BALTIMORE CITY HEALTH DEPARTMENT		72 08429	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type in Print) <b>Blockston, Arlene</b>				2. DATE AND HOUR OF DEATH <b>8/29/72 12:50 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hosp</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> COUNTY <b>Maryland</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>114 RIDGE LINE</b> <b>114 Ridge Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-42</b>		9. AGE (In years last birthday) <b>30</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Frank Fromm</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-40-1864</b>		17. INFORMANT <b>Mr. James W. Blockston</b> ADDRESS <b>114 Ridge Ave.</b>			
18. <b>430.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>SUBARACNOID HEMORRHAGE</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Ruptured Aneurysm, (IC) Int. Cereb.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 DAYS</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>(A)</b> (this hospital) attended the deceased from <b>8/23/72</b> 19 <b>72</b> to <b>8/29</b> 19 <b>72</b> that <b>(B)</b> (we) last saw the deceased alive on _____ 19 _____ and that in <b>(C)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(D)</b> (We) (did) <b>(view)</b> view the body after death.							
23A. SIGNATURE <b>J.H. Ziegler M.D.</b>				23B. DATE SIGNED <b>8/29/72</b>		23C. PHYSICIAN'S NAME (Type) <b>J.H. Ziegler M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-1-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Dorothy Blockston</b>		25C. FUNERAL DIRECTOR <b>McSubly Funeral Homes</b> ADDRESS <b>237 Patapsco Av. 21225</b>			

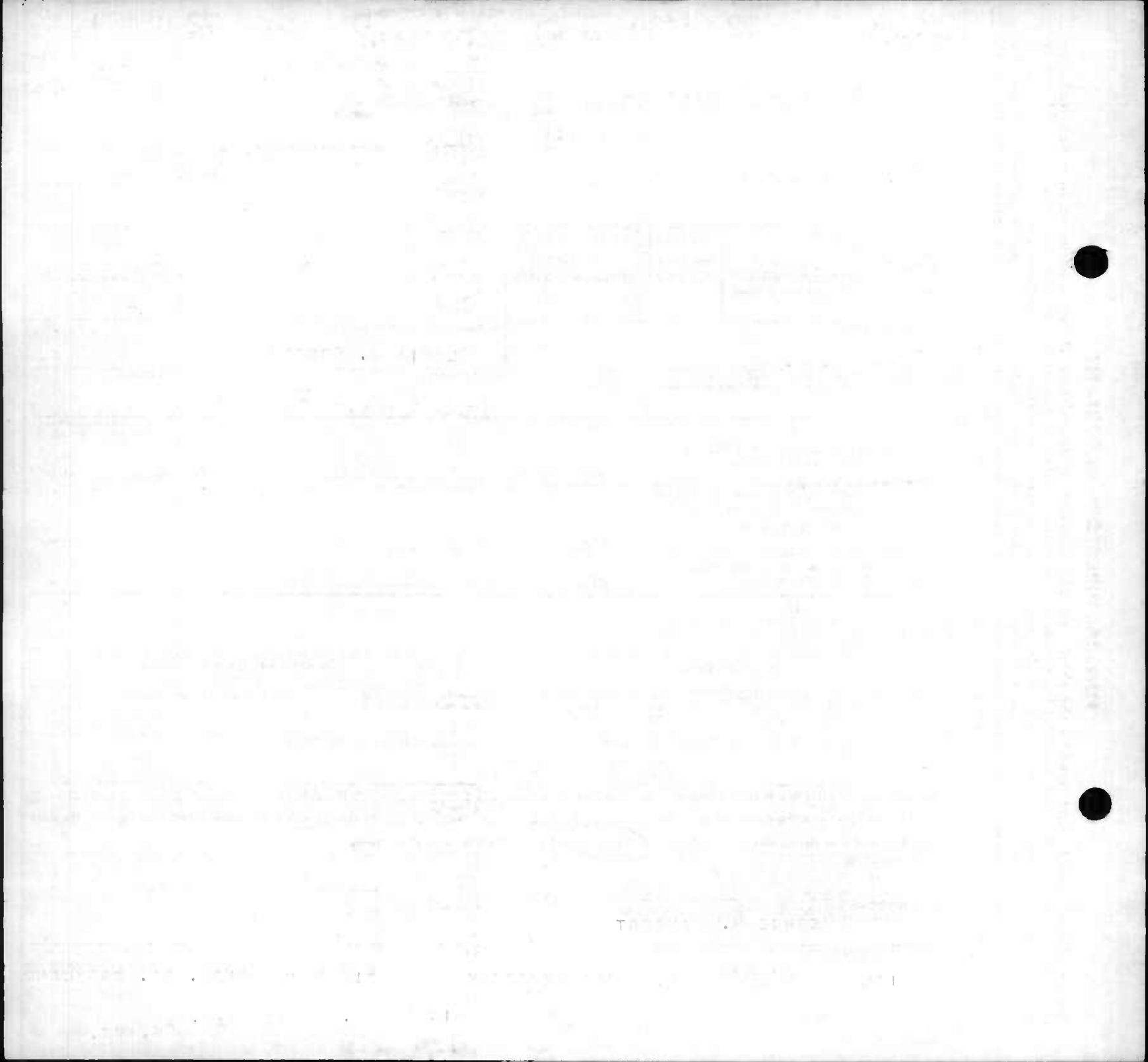




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

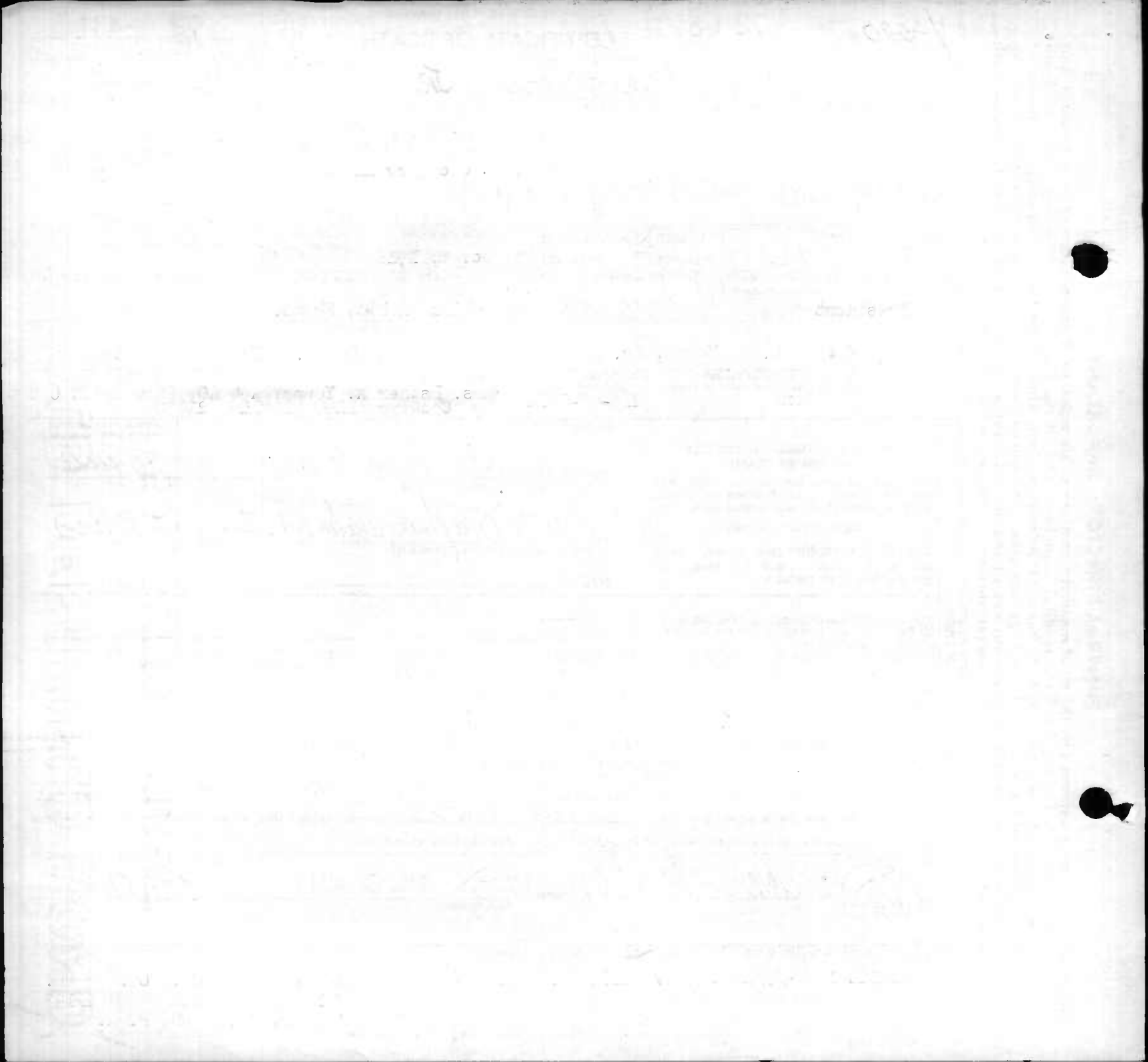
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08430	
G-434-72 08430				STATE OF MARYLAND-DHMH	
BIRTH NO. <u>Washington Md</u>		1. NAME OF DECEASED (Type or Print) <u>RICHARD GLADWILL</u>			
2. DATE AND HOUR OF DEATH <u>8/26/72</u> <u>19<sup>20</sup></u> A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>NASH.</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>			
5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/24/72</u>		9. AGE (In years last birthday) <u>0</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>BILL GLADWILL</u>		14. MOTHER'S MAIDEN NAME <u>GLORIA J. GORDON</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Pt's CHART From Washington County</u>	
18. <u>746.71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CONGENITAL HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>8/25</u> 19 <u>72</u> to <u>8/26</u> 19 <u>72</u> that (1) (we) last saw the deceased alive on <u>8/26</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George H. Lambert</u>				23B. DATE SIGNED <u>8/26/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>GEORGE H. LAMBERT</u>				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>8/29/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>PARKHEAD CEMETERY</u>	
24D. LOCATION <u>BIG POOL WASH. CO. MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>			
25B. NAME OF REGISTRAR <u>Richard J. Grove</u>		25C. FUNERAL DIRECTOR <u>RICHARD J. GROVE HANCOCK, MD.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-520		72 08431		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 (8431)	
BIRTH NO.		CERTIFICATE OF DEATH		STATE OF MARYLAND-DHMH			
1. NAME OF DECEASED (Type or Print)		John Odgers Young Jr.		2. DATE AND HOUR OF DEATH		9/1/72, 4 <sup>52</sup> P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		Baltimore	
Maryland General Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Cockeysville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER		Snow Drift Court Apt 4G	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days	11. UNDER 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY?
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec 6, 1916	55			USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
President		Progressive Press Co		Philadelphia, Penna.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
John O. Young, Sr.		Sarah W. Young (Roberts)		No None		218-03-7712	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No None		218-03-7712		Mrs. Esther A. Young, Apt 4G, Snow Drift Court		Cockeysville, Maryland 21030	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		50 min			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		± 3 hrs			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0		NO		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
NO							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
APPROXI							
22. I certify that (I) (this hospital) attended the deceased from		9/1 1972 to		9/1 1972			
that (I) (we) lost saw the deceased alive on		9/1 1972		and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
[Signature]		9/1/72		[Signature]		[Address]	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
ENTOMBMENT		9/5/1972		LORRAINE PARK MAUSOLEUM		WOODLAWN BALTO., CO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 5 1972		[Signature]		LORING BYERS		21133	
				FUNERAL DIRECTORS, P. A.			



Released on approval - medical examiner's office

**FUNERAL DIRECTOR: IMPORTANT**

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S-363		72 08432		BALTIMORE CITY HEALTH DEPARTMENT		72 08432	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO. STATE OF MARYLAND - DEATH	
1. NAME OF DECEASED (Type or Print) <u>Clinton Stewart</u>				2. DATE AND HOUR OF DEATH <u>8/27/72</u> <u>11:00 pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>				A. STATE <u>Md.</u>		B. COUNTY <u>Balto.</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1810 N. Smallwood St.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-21</u>	9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Costello</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Stewart</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ernestine Stewart</u>		ADDRESS <u>same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>E 940X</u> <u>Chronic Anoxic Encephalopathy</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>Chronic Anoxic Encephalopathy</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street 5</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>RT 360 Warsaw, Virginia V43</u>			
21D. TIME OF INJURY (APPROX.) <u>11-1-69 3:40 PM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Auto accident - driver hit pole</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> 19 <u>72</u> to <u>7/26</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>7/26</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Mark H. Kasowitz</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/28/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARK H. KASOWITZ</u>				23D. ADDRESS <u>MD University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-1-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Aebutus Mem. Pk. Balto., Md.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>		25B. NAME OF REGISTRAR <u>John E. H.</u>		25C. FUNERAL DIRECTOR <u>U. Bailey</u>		ADDRESS <u>1348 Calhoun St.</u>	

1940

Chas. Brown

Street (last name) (last name)  
(last name)

DM

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1940  
X 1940 - 1940

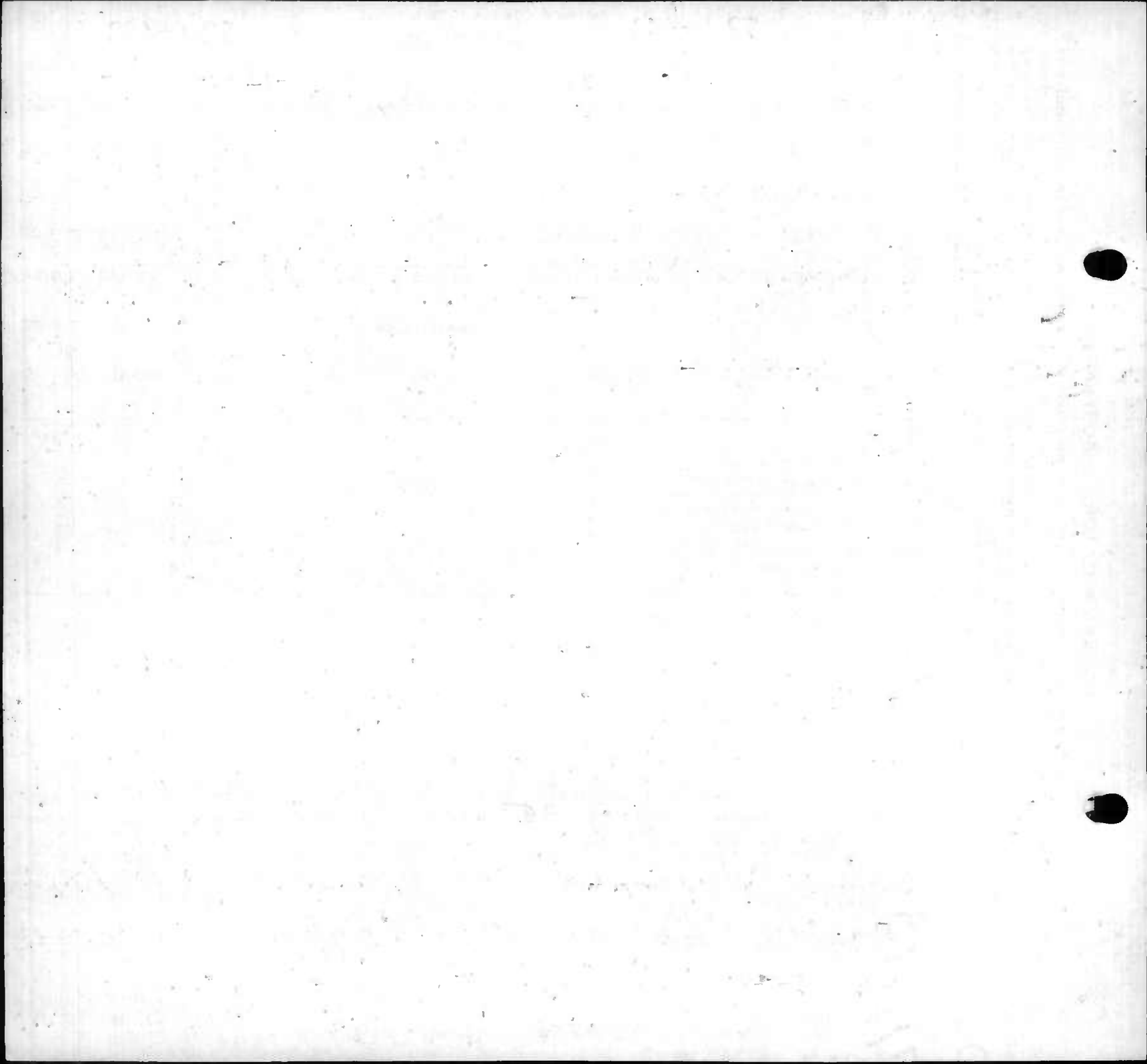
1940



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68





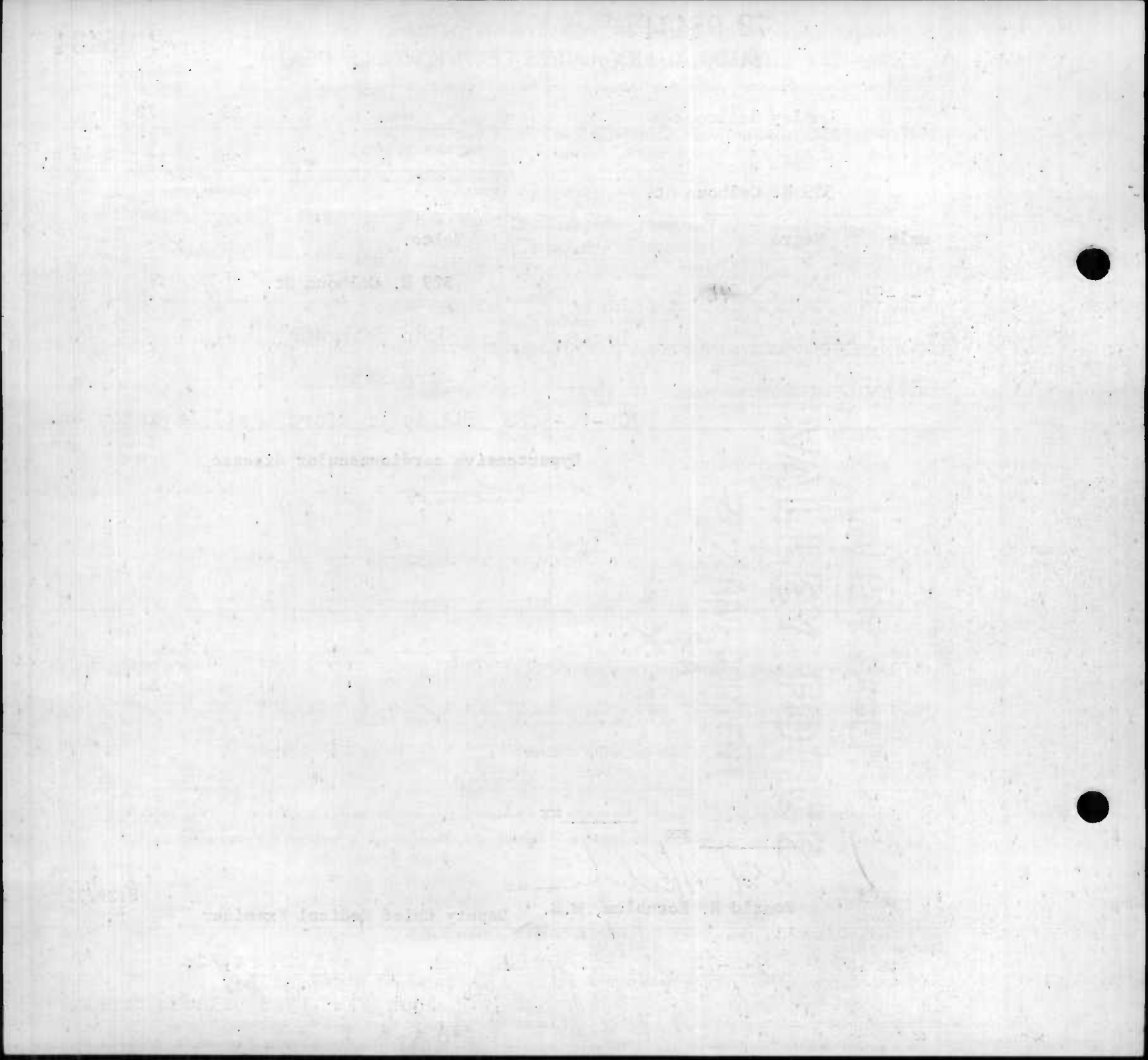
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08434

BIRTH NO.

REG. NO.

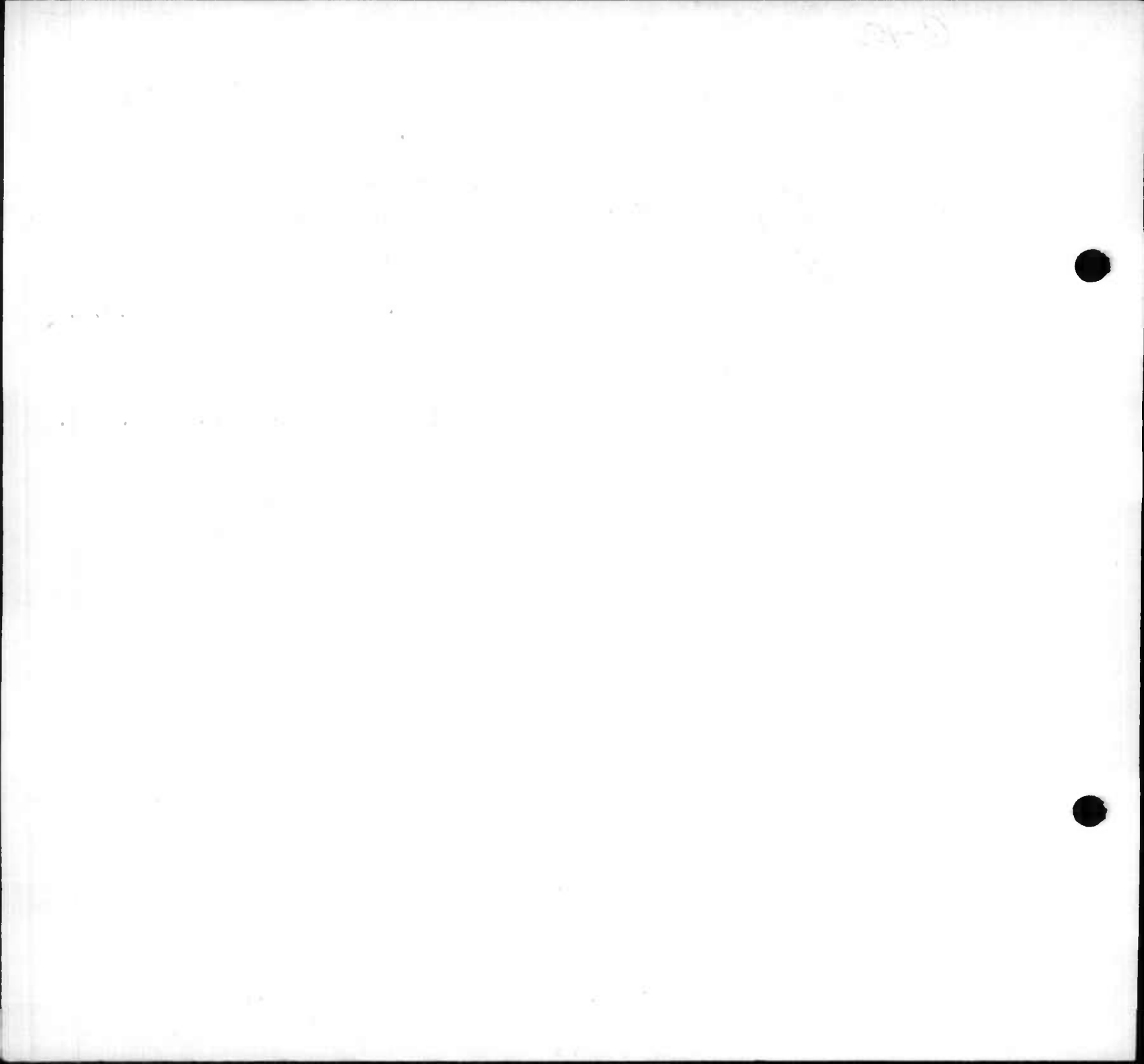
1. NAME OF DECEASED (Type or Print) Wesley Seabrook		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 8 Day 29 Year 72 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 529 N. Calhoun St.		3. DATE PRONOUNCED DEAD Month 8 Day 29 Year 72 Hour 8:40 a. M.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7-4-98		10. AGE (In years last birthday) 74	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 709-12-5680	
18. INFORMANT Lillie Bradford		ADDRESS 1411 Division St.	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/29/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-2-72	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

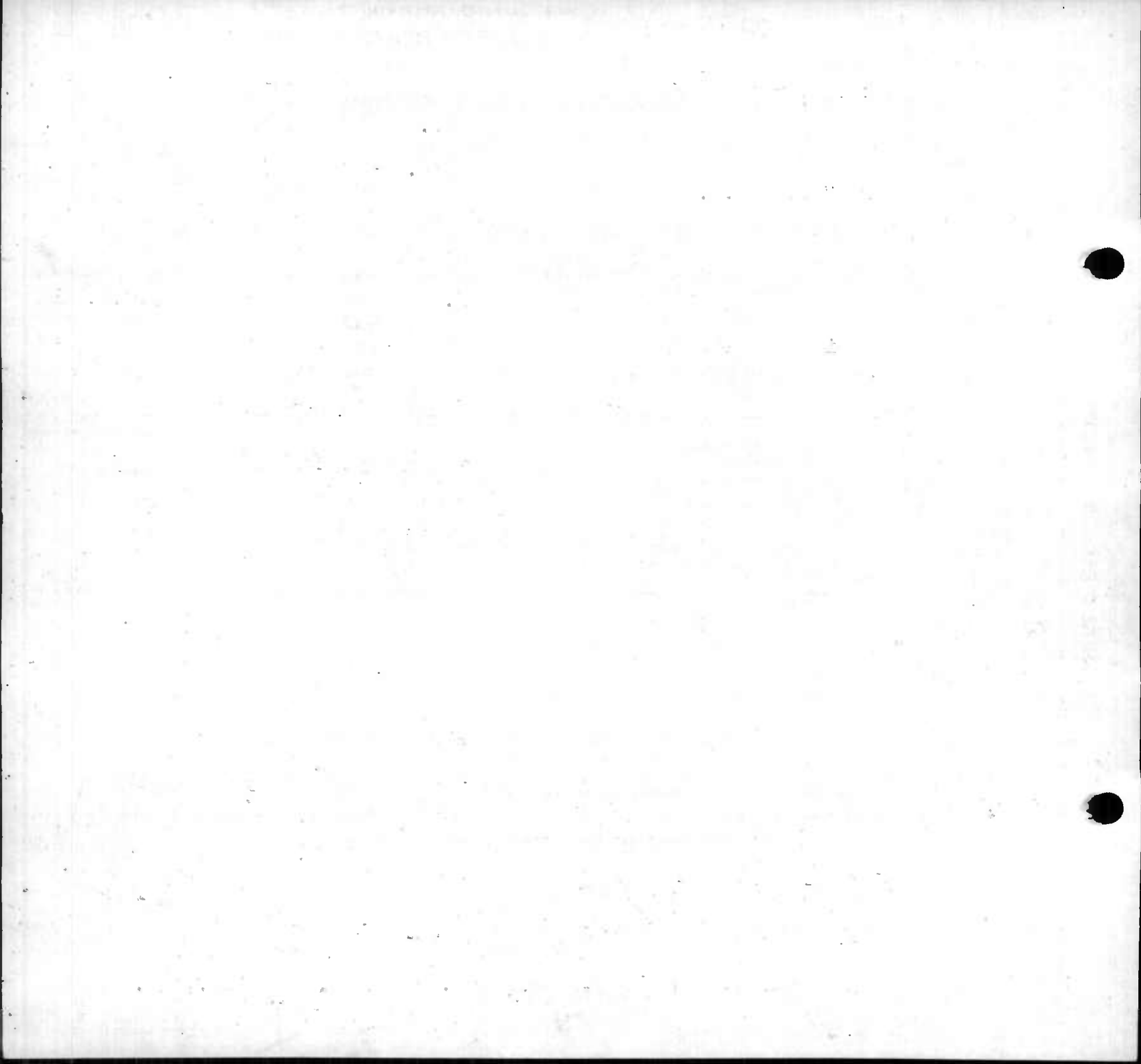
<p><b>G-456</b>      <b>72 08435</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>72 08435</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>STATE OF MARYLAND - DHMH</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <i>Elois Gilmore</i></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <i>9/1/72 1:12 PM</i></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</b> A. STATE <i>Md.</i> B. COUNTY <i>1537</i></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <i>Lutheran Hospital of Maryland</i></p>		<p><b>C. CITY OR TOWN</b> <i>Baltimore</i> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>5. SEX</b> <i>Female</i> <b>6. RACE</b> <i>N</i> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <i>7-5-36</i> <b>9. AGE (In years last birthday)</b> <i>36</i></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <i>Va.</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i></p>	
<p><b>13. FATHER'S NAME</b> <i>Linwood Meally</i></p>		<p><b>14. MOTHER'S MAIDEN NAME</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p><b>16. SOCIAL SECURITY NO.</b></p>	
<p><b>17. INFORMANT</b> <i>Henry Gilmore</i> <b>ADDRESS</b> <i>4644 Pk. Hts. Ave.</i></p>		<p><b>18. CAUSE OF DEATH</b></p>	
<p><b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE</b> <i>SUBARACHANOID HEMORRAGE</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <i>Rupture of cerebral aneurysm.</i> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b></p>	
<p><b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No)</p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If in Baltimore City, give exact location)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b></p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>8/26/72</i> <b>to</b> <i>9/1/72</i> <b>and that (I) (we) last saw the deceased alive on</b> <i>19</i> <b>and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>		<p><b>23A. SIGNATURE</b> <i>E. S. SANDOZ</i> <b>DEGREE</b> <i>MD</i> <b>23B. DATE SIGNED</b> <i>9/1/72</i></p>	
<p><b>23C. PHYSICIAN'S NAME (Type)</b> <i>E. S. SANDOZ</i> <b>DEGREE</b> <i>MD</i></p>		<p><b>23D. ADDRESS</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <i>Burial</i> <b>24B. DATE</b> <i>9-5-72</i></p>		<p><b>24C. NAME of CEMETERY or CREMATORY</b> <i>Mt. Auburn Cem.</i> <b>24D. LOCATION</b> (City, town, or county) (State) <i>Balto., Md.</i></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <i>SEP 5 1972</i> <b>25B. NAME OF REGISTRAR</b> <i>Sidney W. Kelson</i></p>		<p><b>25C. FUNERAL DIRECTOR</b> <i>V. Bailey</i> <b>ADDRESS</b> <i>1348 Calhoun Street</i></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72-08436	
B-520 72 08436				STATE OF MARYLAND-DHMH	
1. NAME OF DECEASED (Type or Print) <b>Rachel Banks</b>				2. DATE AND HOUR OF DEATH <b>4/10 PM 8/31/72</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Caton Manor N.H.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2006</b>	
5. SEX <b>F</b>		6. RACE <b>N</b>		C. CITY OR TOWN <b>Balto.</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-11-90</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		E. STREET AND NUMBER <b>3110 Leeds Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. AGE (In years last birthday) <b>82</b>	
13. FATHER'S NAME <b>Nicolas Johnson</b>			14. MOTHER'S MAIDEN NAME <b>Mary J. Waters</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-16-1952A</b>		17. INFORMANT <b>Bernice Farmer same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1922</b> to <b>8/31/72</b> 19, that (I) (we) last saw the deceased alive on <b>8/31</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Damian Palagia</b> DEGREE				23B. DATE SIGNED <b>8/31/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DAMIAN PALAGIA</b> DEGREE				23D. ADDRESS <b>305 Frederick Rd</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-5-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Western Star Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney Whitson</b>		25C. FUNERAL DIRECTOR <b>V. Bailey</b> ADDRESS <b>Kelson F.H. 1348 Calhoun Street</b>			





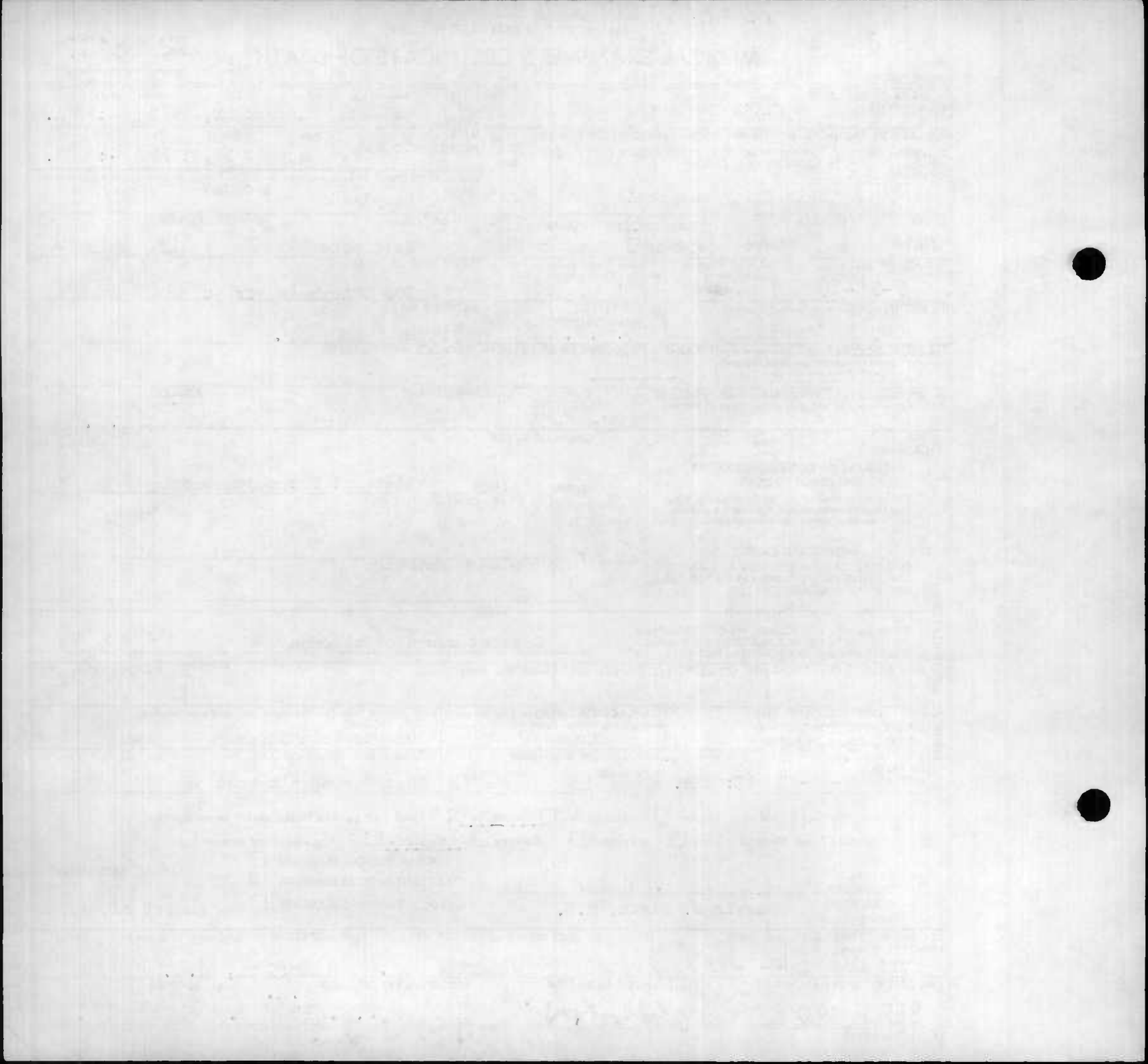
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08437

REG. NO.

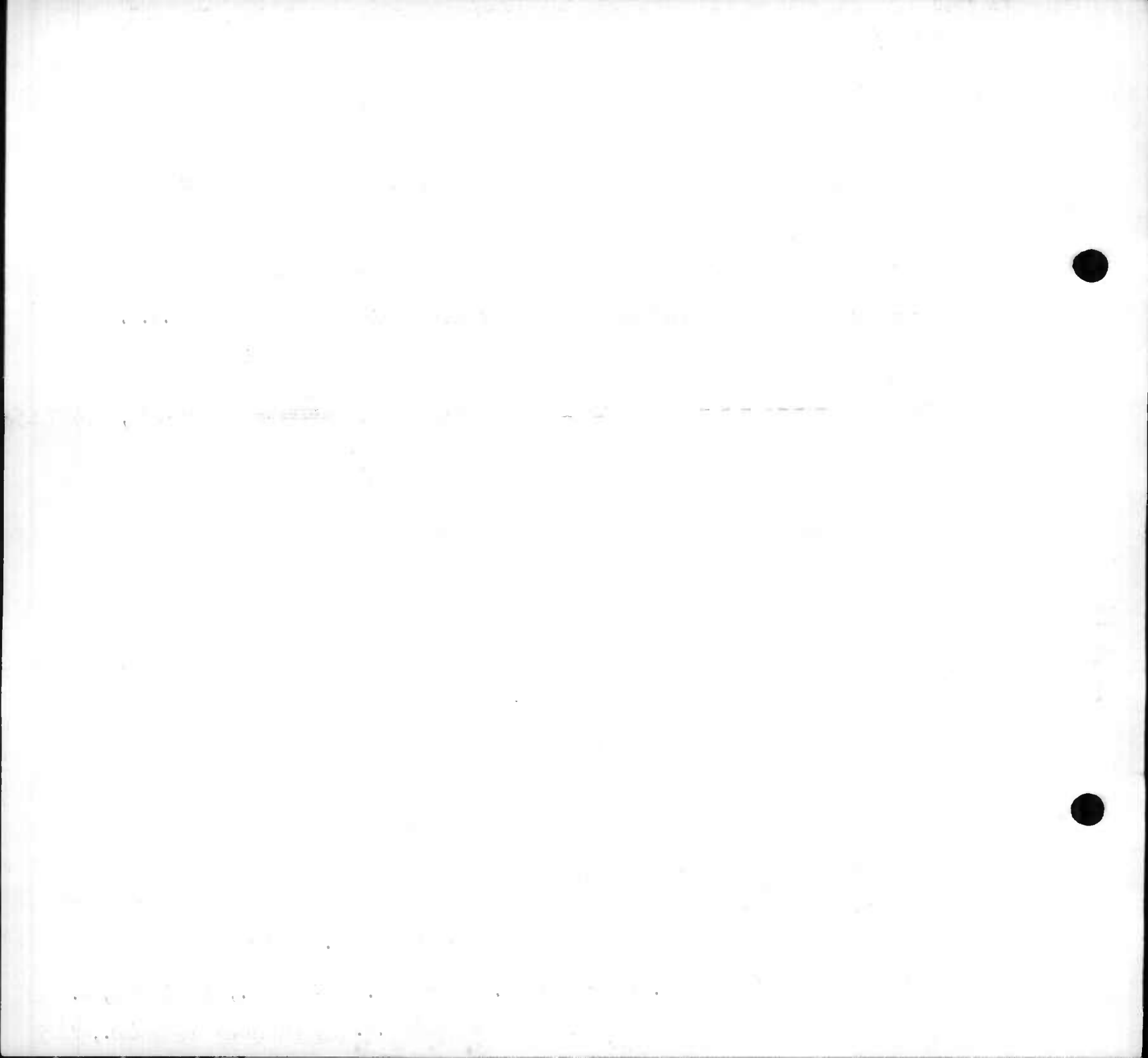
BIRTH NO.

1. NAME OF DECEASED (Type or Print) WARREN DAVIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year August 31, 1972 Estimated <input type="checkbox"/> Hour 4:30 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year August 31, 1972 Hour 4:30 A. M.	
6. SEX Male		8. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-15-29		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 40 1/2		E. STREET AND NUMBER 508 Otterbein Street	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warren Davis Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction	
14B. KIND OF BUSINESS OR INDUSTRY -----		15. MOTHER'S MAIDEN NAME Frances Garris	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 249-48-0770	
18. INFORMANT Lorraine Davis		ADDRESS 1851 Spencer Greensboro, N.C.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Gunshot wound of abdomen		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 509 Otterbein Street		22D. TIME OF INJURY (APPROX.) 7-31-72 12:01 A. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED August 31, 1972			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-7-72	
24C. NAME OF CEMETERY or CREMATORY Bethlehem Church Cem.		24D. LOCATION (City, town, or county) (State) Summerton, S.C.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR Sidney [Signature]	
25C. FUNERAL DIRECTOR V.R. Bailey		ADDRESS Kelson, F.H. 1348 N. Calhoun St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

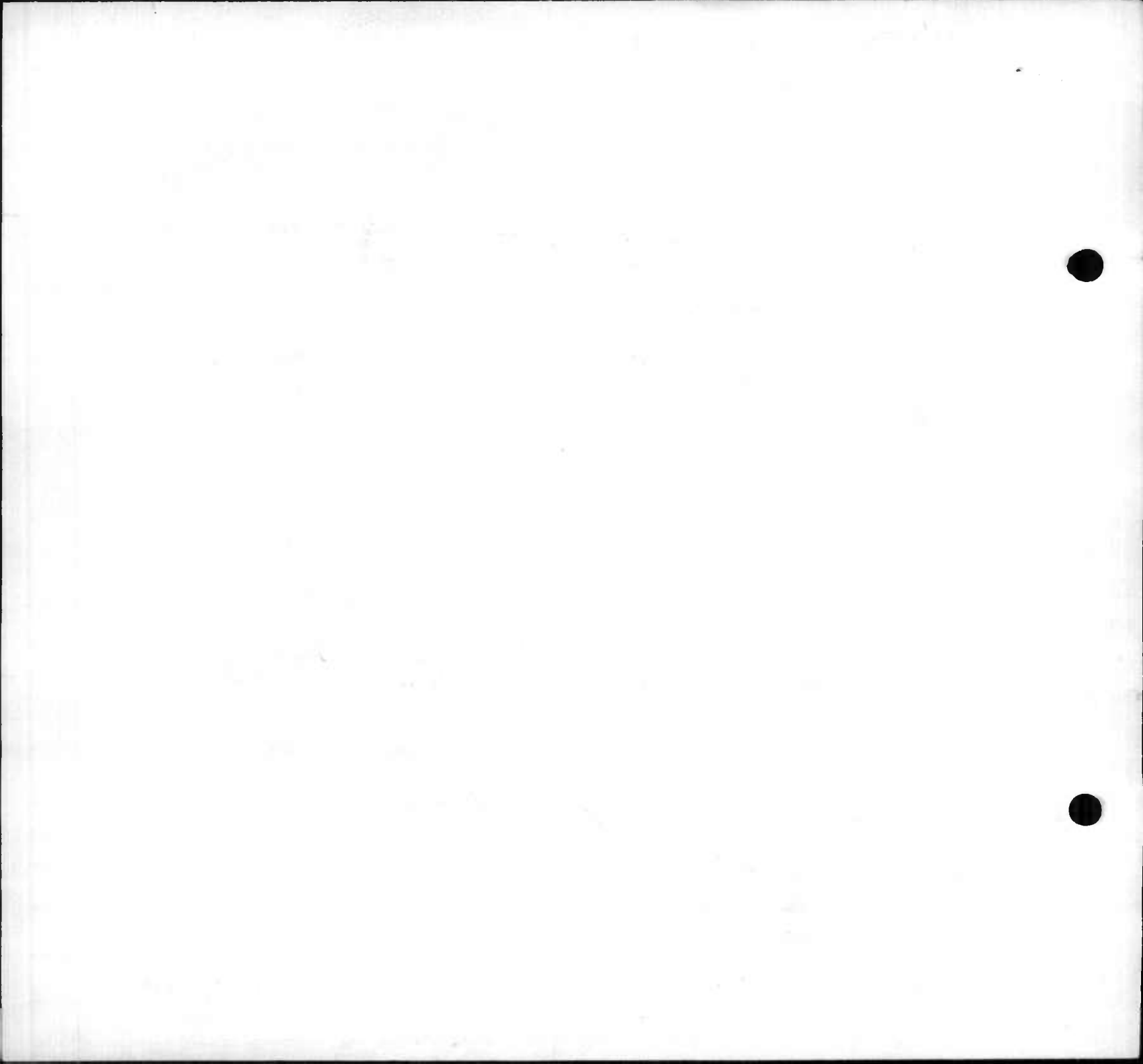
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08438</b>	
<b>CERTIFICATE OF DEATH</b>		STATE OF MARYLAND-DEHM	
1. NAME OF DECEASED (Type or Print) <b>McFadden, Harry T.</b>		2. DATE AND HOUR OF DEATH <b>Sept. 2, 1972 8:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland Hospital</b>		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2534</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>614 Arsan Avenue 21225</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-13-1892</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	9. AGE (In years last birthday) <b>79</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas McFadden</b>		14. MOTHER'S MAIDEN NAME <b>Anne Landes</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>207-03-0214A</b>	
17. INFORMANT <b>Son</b>		ADDRESS <b>3423 6th St. Balto 21225</b>	
18. <b>203X1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HEMORRHAGE</b> <b>MULTIPLE MYELOMA</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Sept 2 19 72</b> to <b>Sept 2 19 72</b> that (I) (we) last saw the deceased alive on <b>Sept 2 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Yale D. Boyer MD</b>		23B. DATE SIGNED <b>9/2/72</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>University of Md. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/6/1972</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. Stephens Luth. Church Cem. Juniata Co., Mifflintown, Pa.</b>		24D. LOCATION (City, town, or county) (State) <b>Pa.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>David H. Gordon</b>	
25C. FUNERAL DIRECTOR <b>Mc Cully F.H.</b>		ADDRESS <b>237 Patapsco Ave Balto., 21225</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 08439
G-520 BIRTH NO.		72 08439		STATE OF MARYLAND-DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
GENCO MARY T		8-30-72 12.50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
CHURCH HOME & HOSPITAL.		BALTIMORE, MARYLAND. 603		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		2221 E. Fayette St.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-1-88	83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
HOUSEWIFE - Seamstress ✓				✓ ITALY
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?		
SALVATORE TESTADINE		U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No		215 03 9041		FRANK GENCO. 2221 E. FAYETTE ST. BALTIMORE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		Metastatic cervical cancer; Cerebral vascular accident		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		Cervical Cancer		
		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
8-13-72		Tracheotomy		No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 8-6-72 to 8-30-72 that (I) (we) last saw the deceased alive on 8-30-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
J. Kim M.D.				
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
DR. JUNG-HO KIM M.D.		CHURCH HOME & HOSPITAL BALTIMORE, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		9/26/72		Gardens of Faith Cemetery
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		
Baltimore, Maryland		John A. Moran, Inc.		
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS
SEP 5 1972		[Signature]		3000 E. Baltimore St. BALTIMORE, MD. 21224

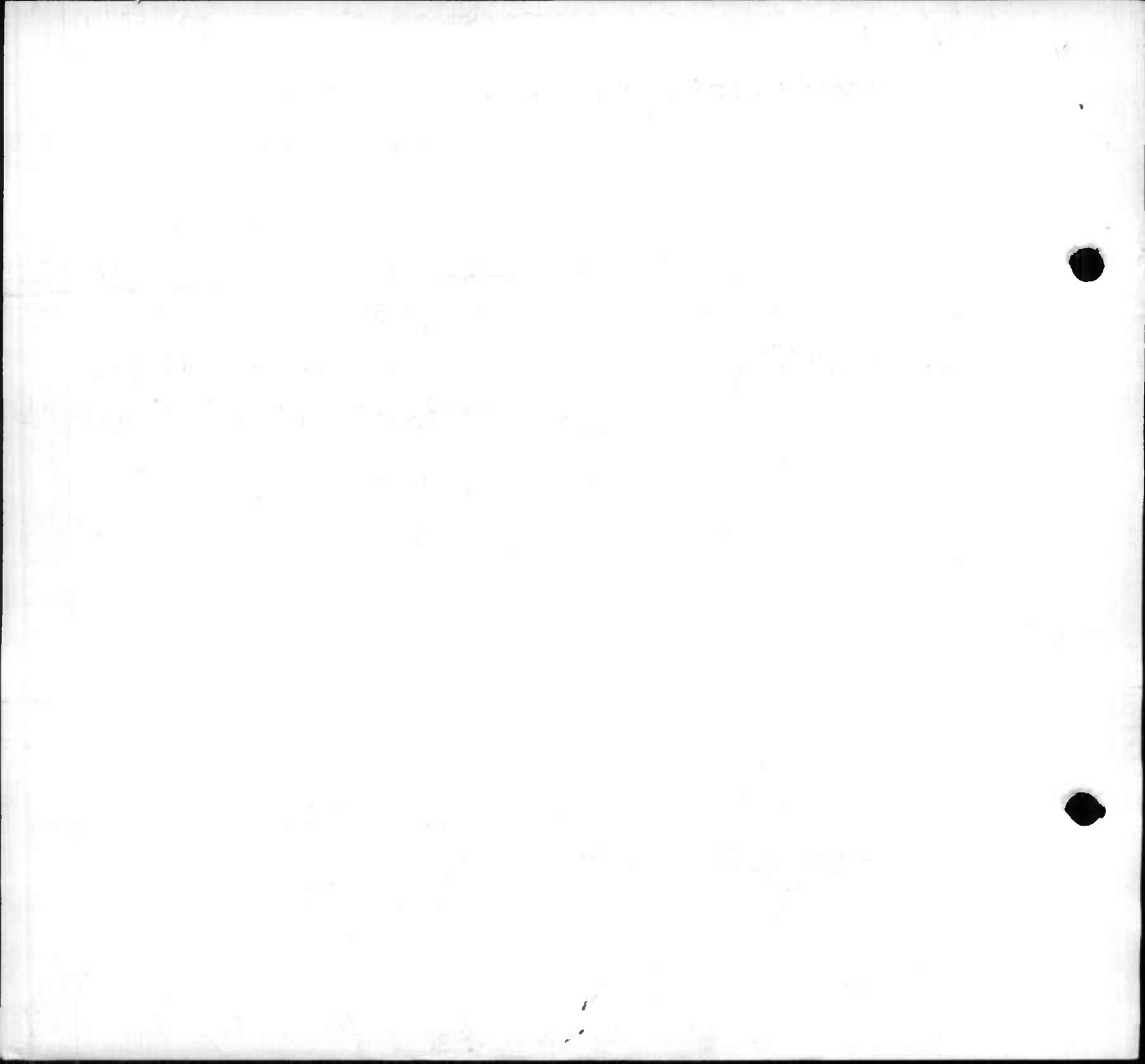


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08440	
CERTIFICATE OF DEATH				STATE OF MARYLAND - <del>DEPT</del>	
T-460 BIRTH NO. <u>08440</u>		REG. NO. <u>72 08440</u>			
1. NAME OF DECEASED (Type or Print) <u>BERNANTRAY LYNN TAYLOR</u>		2. DATE AND HOUR OF DEATH <u>8/28/72</u> <u>12:10 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Dorchester</u> C. CITY OR TOWN <u>Newark</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Box 42 Newark Md. 21841</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/72</u>	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days <u>17</u> <u>25</u> Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>D. RAYMOND TAYLOR</u>			14. MOTHER'S MAIDEN NAME <u>JUDITH (MAIDEN NAME) UNPARKER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Dr. Robert Brinkman</u> ADDRESS <u>8401 N/O</u>		
18. <u>776.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: <u>by history</u> (B) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>217 hr</u> <u>at birth (17 hrs)</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> 19 <u>72</u> to <u>8/28</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/28</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>S. Allan Bock, M.D.</u>		23B. DATE SIGNED <u>8/28/72</u>		23C. PHYSICIAN'S NAME (Type) <u>S. Allan Bock</u>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>8/30/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE</u>	
24D. LOCATION (City, town, or county) <u>Berlin Md</u>		24E. NAME OF REGISTRAR <u>Anthony A. Buehler</u>		24F. FUNERAL DIRECTOR <u>Berlin Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

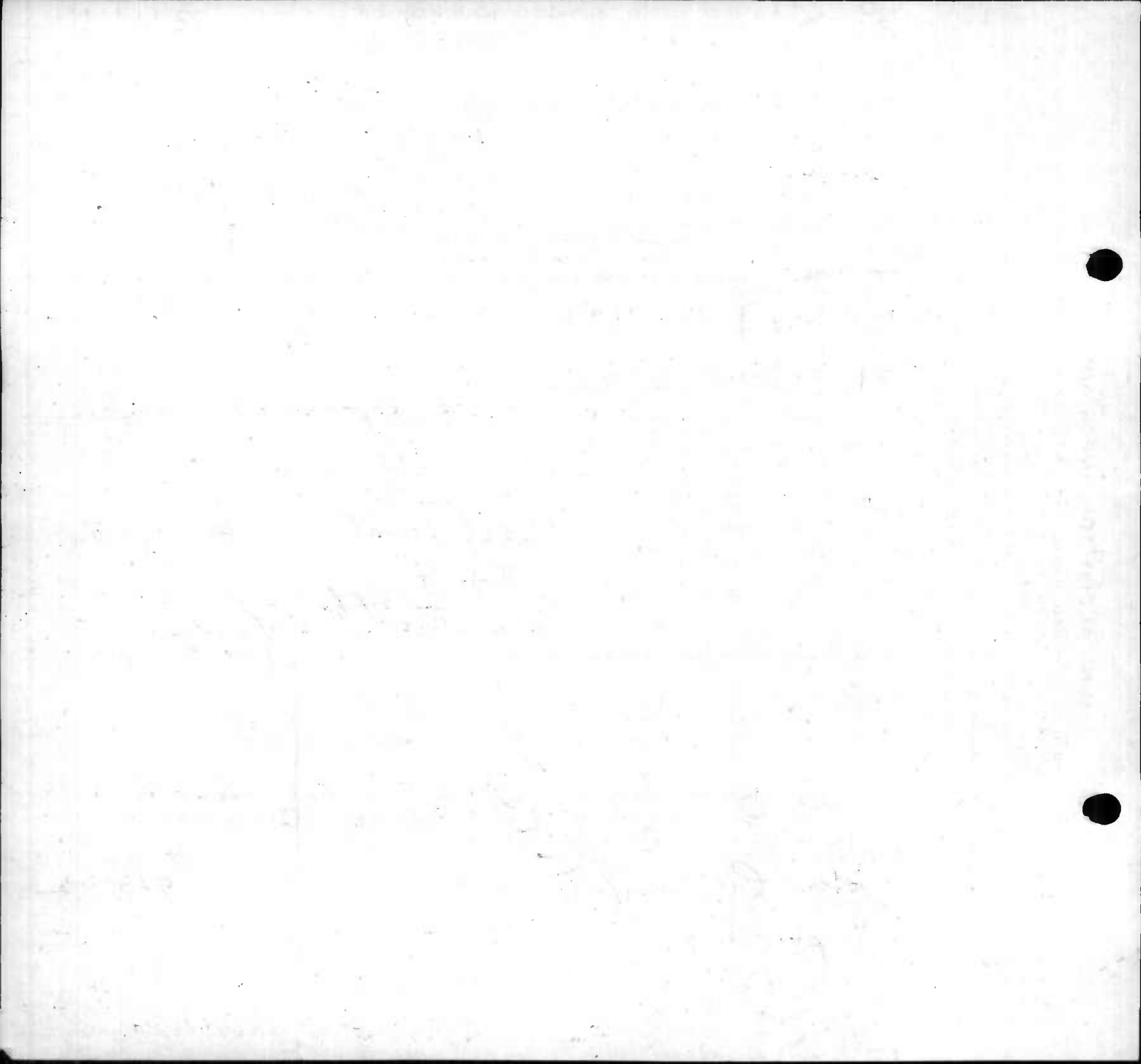




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08441	
W-325		72 08441	
BIRTH NO.		STATE OF MARYLAND-DEMD	
1. NAME OF DECEASED (Type or Print) <i>Ida F. Watson</i>		2. DATE AND HOUR OF DEATH <i>Sept 2-1972 7:10 Am.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Caton Manor Nursing Center</i>		C. CITY OR TOWN <i>Arbutus</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-10-1880</i>	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>92</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Godwin</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Oliver</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-56-0414</i>	
17. INFORMANT <i>Rita C. Egan</i>		ADDRESS <i>4624 Magnolia Ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>436.91</i>		CAUSE OF DEATH <i>Uremia</i>	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Arteriosclerosis Sclerotic</i> DUE TO, OR AS A CONSEQUENCE OF: <i>CVA</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Congestive Heart Failure</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>June 1, 1972</i> to <i>Sept 2, 1972</i> , that (1) (we) last saw the deceased alive on <i>Aug 28, 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>John Healey</i>		23B. DATE SIGNED <i>9/3/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. John Healey</i>		23D. ADDRESS <i>1311 Francis Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/5/72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 5 1972</i>		25B. NAME OF REGISTRAR <i>Anthony...</i>	
25C. FUNERAL DIRECTOR <i>Ambrosi, Inc.</i>		ADDRESS <i>1328 Sulphur Sp. Rd.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>D-320</u> <u>72 08442</u>				BALTIMORE CITY HEALTH DEPARTMENT		72 08442	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Maria Dudeck</u>				2. DATE AND HOUR OF DEATH <u>8-31-1972</u> <u>9:05 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>101</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>House of the Sisters Belair Rd</u> <u>70</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1110 S. Becker Ave.</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-1896</u>	9. AGE (In years last birthday) <u>76</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hamstress</u>	11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>217-14-3221</u>	
17. INFORMANT <u>Henry Dudeck</u>		ADDRESS <u>same</u>		18. <u>436.914174X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic Brain Lesion; Rt. metastasis for Carcinoma 3 yrs.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Cardiovascular Disease</u> (B) <u>Granulosis Anterioris</u> (C) <u>gum</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>6/27/1971</u> to <u>8/31/1972</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>8/23/1972</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> (did not) view the body after death.							
23A. SIGNATURE <u>Albas B. Brady</u>				23B. DATE SIGNED <u>9/1/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>Albas B. Brady</u>				23D. ADDRESS <u>same</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-2-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>		25B. NAME OF REGISTRAR <u>Adrienne W. Brown</u>		25C. FUNERAL DIRECTOR <u>Thelma A. Hoffmann</u>		ADDRESS <u>3218 Hudson St.</u>	

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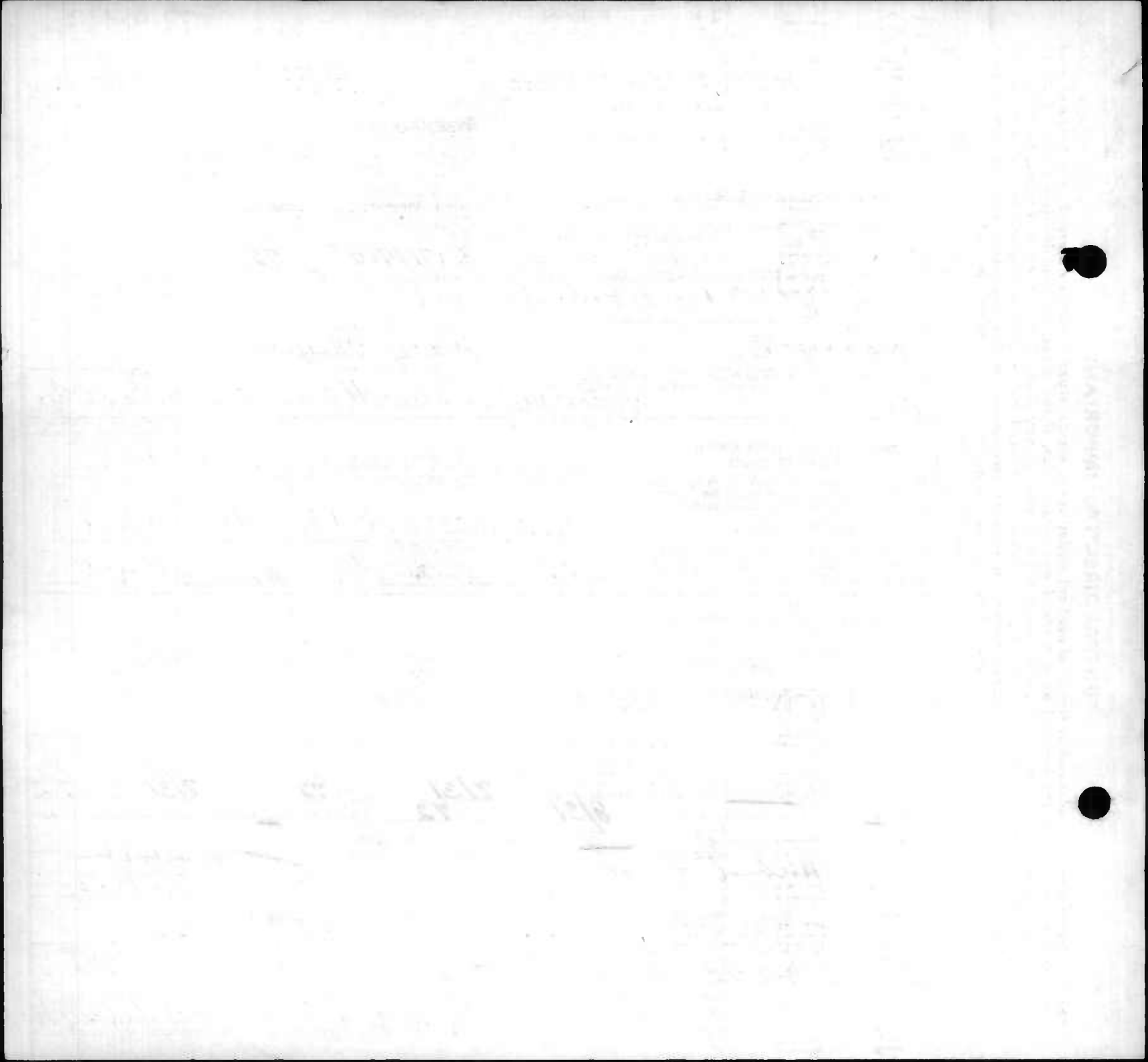
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520		72 08443		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08443	
BIRTH NO.		72 08443		CERTIFICATE OF DEATH		STATE OF MARYLAND - DIED	
1. NAME OF DECEASED (Type or Print) <b>THEKER, William L. Thomas</b>				2. DATE AND HOUR OF DEATH <b>8/31/72</b>		5:15 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2610</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>504 N. East Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/17/1900</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>B+O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Harry E.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Myers</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>705-05-2660</b>		17. INFORMANT <b>Mrs. Helen Thomas</b>		
			ADDRESS <b>504 N. East Ave.</b>				
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiorespiratory arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
				(B) <b>Chest pain - probable MI</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>2 hrs</b>	
				(C) <b>Coronary artery d.</b>		<b>10 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>8/31</b> 19 <b>72</b> to <b>8/31</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/31</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. W. Michael Tucker</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>8/31/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael Tucker, M.D.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-2-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Indy...</b>		25C. FUNERAL DIRECTOR <b>Helmer &amp; Hoffman</b>		ADDRESS <b>3218 Hudson St</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

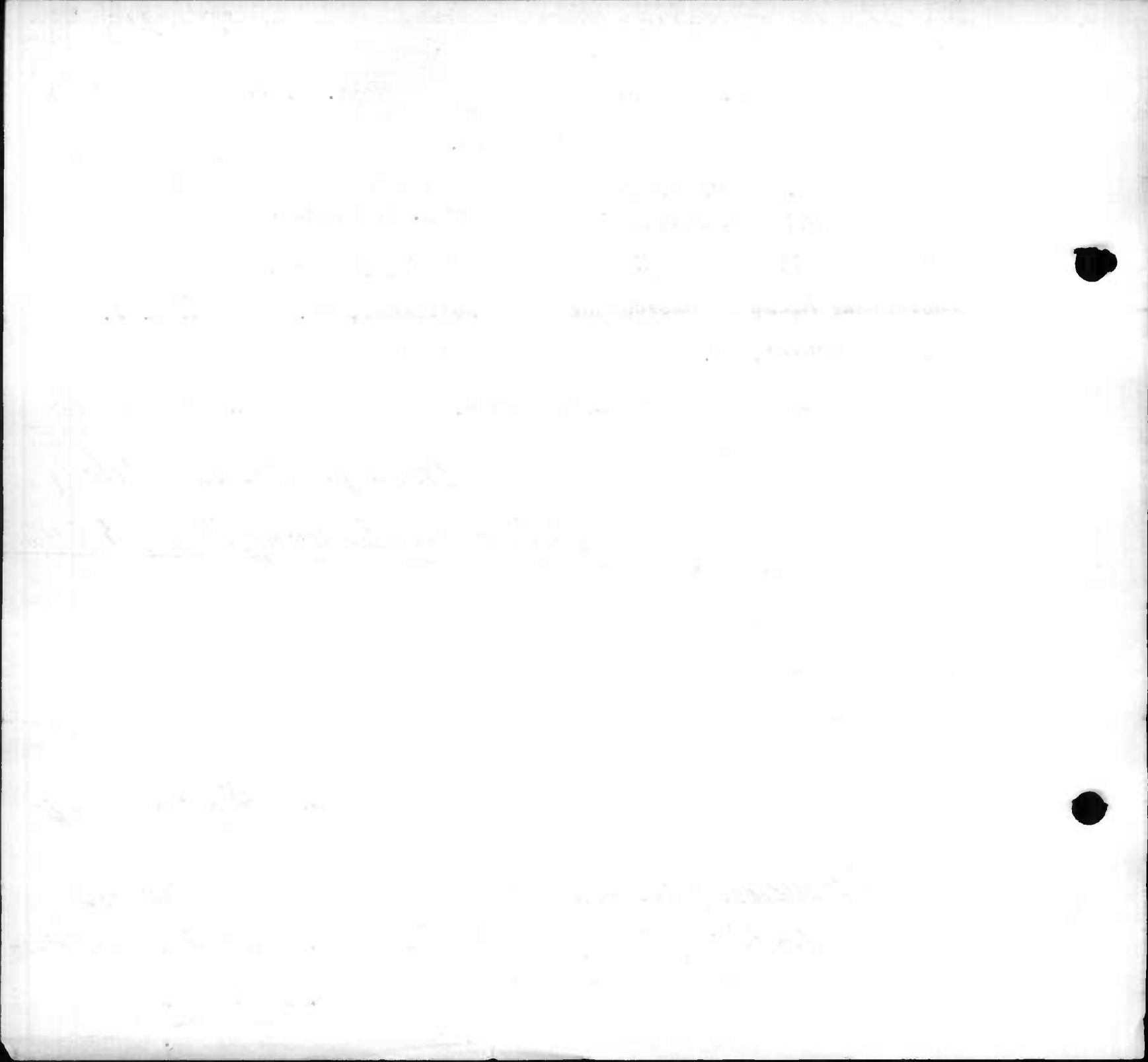
BALTIMORE CITY HEALTH DEPARTMENT				72 08444	
H-536				72 08444	
BIRTH NO.				72 08444	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Daniel Hunter				8-31-72 4-45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
46 Lutheran Hosp.				Md 1504	
E. STREET AND NUMBER				2027-Herbert ST	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
M		N		8. DATE OF BIRTH 6-26-21	
9. AGE (In years lost birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10A. USUAL OCCUPATION		10B. KIND OF BUSINESS OR INDUSTRY		Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT				ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Toxic Psychosis	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				II	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/28/ 1972 to 8/31/ 1972 that (I) (we) last saw the deceased alive on 8/31/ 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. H. Siddiqui				8/31/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. H. Siddiqui				Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		9/7/72		Mt. Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 5 1972		A. J. J. J. J.		W. H. J. J. J.	
24D. LOCATION (City, town, or county) (State)		24E. ADDRESS		24F. ADDRESS	
Baltimore, Maryland		802 Madison		802 Madison	

15-22-8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-526		72 08445		BALTIMORE CITY HEALTH DEPARTMENT		72 08445	
CERTIFICATE OF DEATH				REG. NO. <u>72 08445</u>			
STATE OF MARYLAND-DEME							
1. NAME OF DECEASED (Type or Print) <u>Gerard J. Benkert</u>				2. DATE AND HOUR OF DEATH <u>Sept. 2, 1972</u>   <u>7</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>20 S. Caton Street</u> <u>Baltimore, Maryland</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2047</u>			
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/16/1905</u>	
9. AGE (In years last birthday) <u>66 Yrs</u>		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>			
13. FATHER'S NAME <u>George Benkert, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Anna Wurm</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-1177</u>		17. INFORMANT <u>Mrs. Charles Rostzky-6313 Frederick</u>		ADDRESS <u>Road</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF: <u>1 day</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
(B) <u>Arterio-sclerotic with Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: <u>15 yrs.</u>				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>9/10/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19 23</u> to <u>Sept 2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>19</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Damian Palagia</u>				23B. DATE SIGNED <u>9/2/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>DAMIAN P. Palagia</u>				23D. ADDRESS <u>305 Frederick St. Baltimore, Md. 21208</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>9/5/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>		25B. NAME OF REGISTRAR <u>Shirley H. Roston</u>		25C. FUNERAL DIRECTOR <u>Shirley H. Roston</u>		ADDRESS <u>736 Edmondson Ave. Catonsville, Md. 21228</u>	



W-200

72 08446

STATE OF MARYLAND-DEMH  
BALTIMORE CITY HEALTH DEPARTMENT

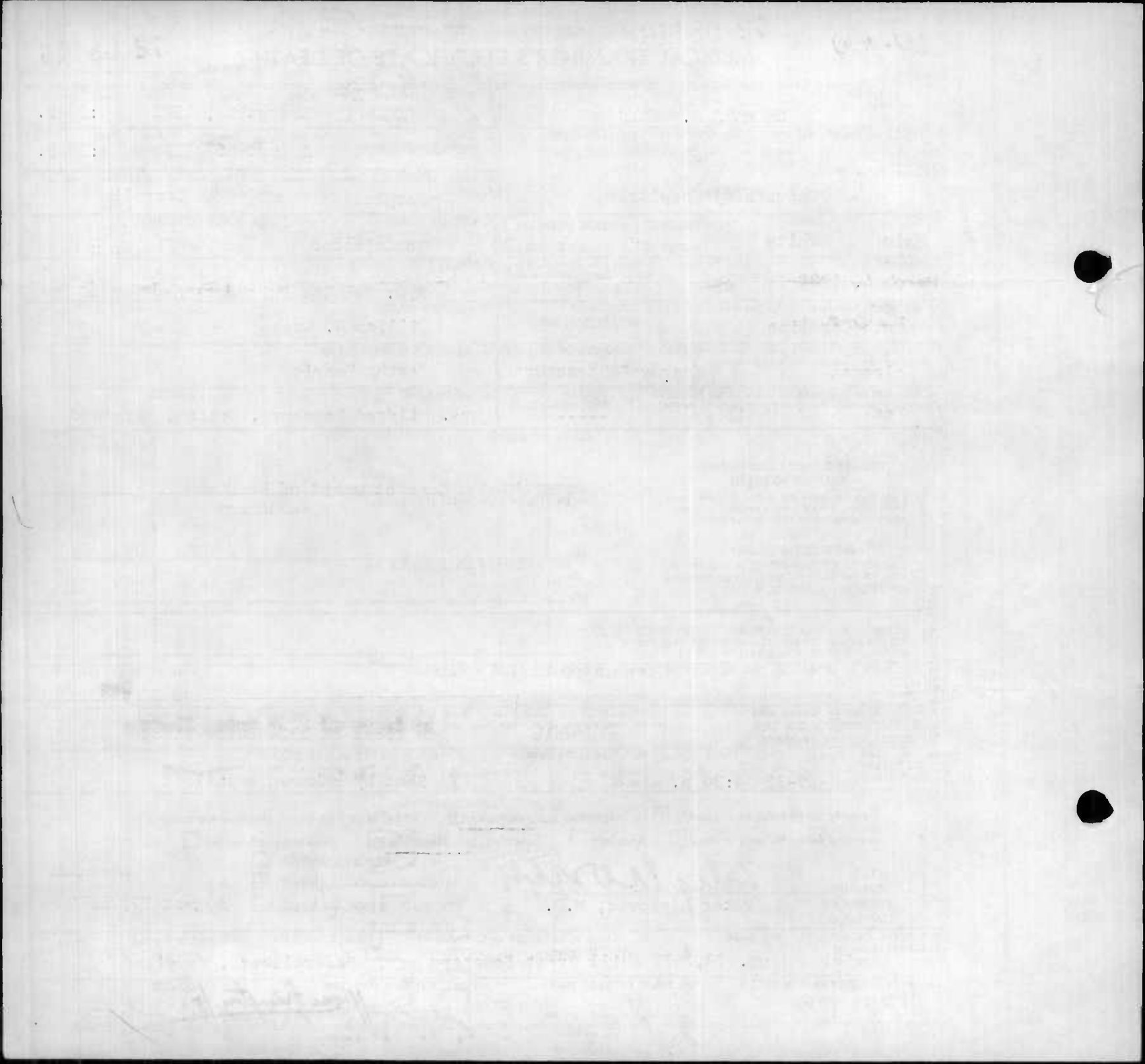
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08446

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES S. WEEKS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>August 26, 1972</b>		Hour <b>4:30 P.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>August 26, 1972</b>		Hour <b>4:30 P.</b>
6. SEX <b>Male</b>		7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>March 4, 1924</b>		10. AGE (In years lost birthday) <b>48</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William W. Weeks</b>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		15. MOTHER'S MAIDEN NAME <b>Bertha Fodrie</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>
17. SOCIAL SECURITY NO. <b>-----</b>		18. INFORMANT ADDRESS <b>Mrs. Mildred Ramsburg, Denton, Maryland</b>		
19. CAUSE OF DEATH <b>E 9651X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE <b>Gunshot wound of head and abdomen</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>sidewalk</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>in front of 2324 Eutaw Place</b>
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>8-19-72 4:30 p. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>August 27, 1972</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Aug. 29, 1972</b>	24C. NAME of CEMETERY or CREMATORY <b>Hill Crest Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		
25B. NAME OF REGISTRAR <b>Aditya...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Frampton Funeral Home, Federalsburg, Md.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08447	
W-536 72 08447				STATE OF MARYLAND - DEPT. OF HEALTH	
1. NAME OF DECEASED (Type or Print) <b>WINTERS WILLA</b>			2. DATE AND HOUR OF DEATH <b>09/02/72 9:15AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2021 ROYAL COURT DRIVE 21207</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09/05/09</b>	9. AGE (in years last birthday) <b>62</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BEAUTICIAN</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>PHILLIP HESS</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE Marley</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>214 07 6716</b>		17. INFORMANT <b>ST AGNES HOSPITAL BALTO MD 21229</b>
18. <b>199.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Cardio. pulm. failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Circumatosis</b>			DUE TO, OR AS A CONSEQUENCE OF: <b>1 yr?</b>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>9-1-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal Obstruction</b>		20A. AUTOPSY? (Yes or No) <b>-</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>-</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>08/21/72</b> 19 to <b>09/02/72</b> 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>09/02/72</b> 19 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (dXXX) view the body after death.					
23A. SIGNATURE <b>[Signature]</b> DEGREE <b>M.D.</b>				23B. DATE SIGNED <b>09/02/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>BAMROTH CERDASO M.D.</b>				23D. ADDRESS <b>ST AGNES HOSPITAL BALTO MD 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/5/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Baltimore Co. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>		25C. FUNERAL DIRECTOR <b>Stansbury Funeral Home 6411 Windsor Mill</b>	



3:15 PM

05/02/72

1 TEST WILLY

MARYLAND

BALTIMORE

2501 ROYAL COURT DRIVE 21217

62

05/02/72

FEMALE CAUCASIAN

W 2 A

MARYLAND

BEAUTICIAN

ANNIE

PHILIP HESS

214 02 2716 ST AGNES HOSPITAL BALTO MD 21228

05/02/72

05/02/72

05/02/72

XXX

05/02/72

X

2501 ROYAL COURT DRIVE 21217

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>X-621</u>				72 08448		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>72 08448</u>	
1. NAME OF DECEASED <u>EMMANUEL A. KRAJCOVIC</u>						2. DATE AND HOUR OF DEATH <u>9/2/72</u> <u>9:30 A</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>BALTIMORE, COUNTY</u>					
<u>BALTIMORE CITY HOSP</u> 4940 Eastern Ave. Baltimore, Md. 21224						C. CITY OR TOWN <u>DUNDALK</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
E. STREET AND NUMBER <u>52 Township Road 5300</u>											
5. SEX <u>Male</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-5-20</u>		9. AGE (In years last birthday) <u>52</u>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY					
<u>ADMIN. TOWER CONTROL-- AIRCRAFT</u>						<u>MARYLAND</u>					
11. BIRTHPLACE (State or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
<u>MARYLAND</u>						<u>USA</u>					
13. FATHER'S NAME <u>John KRAJCOVIC</u>						14. MOTHER'S MAIDEN NAME <u>Agnes GASPARIVIC</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. <u>220072733</u>					
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> WW II						17. INFORMANT <u>4940 Eastern Ave. ADDRESS</u> BCH Records: <u>Baltimore, Md. 21224</u>					
18. <u>437.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> <u>2 HRS</u>					
ANTECEDENT CAUSES						(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>9/2/72</u> 19 <u>72</u> to <u>9/2</u> 19 <u>72</u> that <u>(H)</u> (we) last saw the deceased alive on <u>9/2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <u>(H)</u> (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Mark A. Lipton</u> MD DEGREE								23B. DATE SIGNED <u>9/2/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>MARK A. LIPTON</u> DEGREE								23D. ADDRESS <u>4940 Eastern Ave. Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>9/5/1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>				24D. LOCATION (City, town, or county) (State) <u>BALTIMORE CO., MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>				25B. NAME OF REGISTRAR <u>Sidney J. [unclear]</u>				25C. FUNERAL DIRECTOR <u>W. BROOKS BRADLEY, DUNDALK, MD.</u>			

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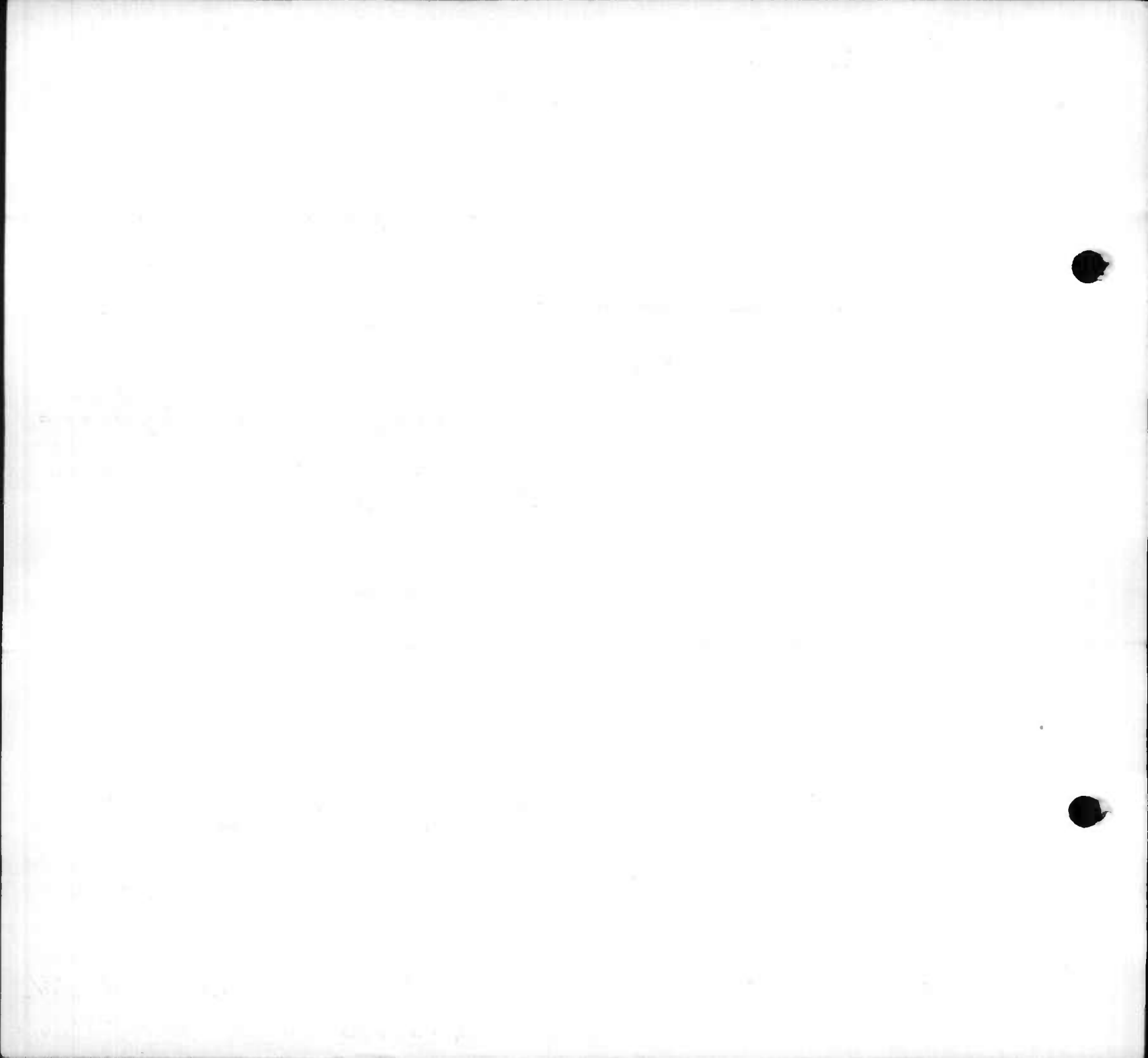
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08449	
BIRTH NO. 3-436 71-17010 72 08449				STATE OF MARYLAND-DEME	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
SLATER AUTUMN L.			8-28-72 11 <sup>10</sup> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Md. B. COUNTY Harco.		
SOUTH BALTO GEN HOSP 3001 S. HANOVER ST. BALTO. MD. 21230.			C. CITY OR TOWN Glen Burnie		
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			E. STREET AND NUMBER 1421 Isted Rd, Glen Burnie		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-71	9. AGE (In years last birthday) 10	10. If Under 1 Yr. Months Days 10 22
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles H. Slater Jr			14. MOTHER'S MAIDEN NAME Mary O'Mahoney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Mother, 1421 Isted Rd, Glen Burnie			ADDRESS Glen Burnie		
18. 036.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Meningococcal sepsis DUE TO, OR AS A CONSEQUENCE OF: Waterhouse-Friedrichsen syndrome (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/28 9:20 PM 1972 to 8/28 11:10 PM 1972 that (I) (we) last saw the deceased alive on 8/28 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE DR ANTE GRGIC			23B. DATE SIGNED 8/28 72		23C. PHYSICIAN'S NAME (Type) DR ANTE GRGIC
23D. ADDRESS S. B. G. H.			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 31 Aug 72			24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. PK		
24D. LOCATION Glen Burnie AA Md.			25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		
25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR W. K. K. Funeral Home, Glen Burnie		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08450		C-350		72 08450		REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lucille Edith Cotton				2. DATE AND HOUR OF DEATH Aug. 30, 1972 5 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE DC B. COUNTY V48				5. CITY OR TOWN Washington D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 2X 3100 Wyman Parkway		E. STREET AND NUMBER 12 Anacostia Rd. Apt. 12							
5. SEX F	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/23/19		9. AGE (In years last birthday) 53		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Seamstress		11. BIRTHPLACE (State or foreign country) DC		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Druitt				14. MOTHER'S MAIDEN NAME Estelle Thomas					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-28-8649		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 202.11 + 250.9 Sepsis, probable		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Mycosis fungoides				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal 8 yrs. +			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus Hypertensive cardiovascular disease				Unknown Unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from May 4 19 72, to Aug. 30 19 72, that (I) (we) last saw the deceased alive on Aug. 30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Edward Lichtenfeld								23B. DATE SIGNED 8/30/72	
23C. PHYSICIAN'S NAME (Type) Jay Lichtenfeld, SA Surg (R)				23D. ADDRESS US PHS Hospital, Balto, Md. 21211					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 9/2/1972		24C. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL CEMETERY		24D. LOCATION (City, town, or county) (State) 7601 SHERIFF ROAD, LANDOVER, MD. 3831 GA. AVENUE, WASHINGTON, D. C.			
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR Sidney Gordon		25C. FUNERAL DIRECTOR LATNEY'S FUNERAL HOME, WASHINGTON, D. C.					

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# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>S-436</span> <span>72 08451</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.2em;">72 08451</span> STATE OF MARYLAND-DHMH	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Anna M. Schlutter</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">September 7, 1972</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.1em;">90 Long Green Nursing Home</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">601</span> C. CITY OR TOWN <span style="font-size: 1.1em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.1em;">3008 E. Baltimore Street</span>	
5. SEX <span style="font-size: 1.1em;">F.</span>	6. RACE <span style="font-size: 1.1em;">W.</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">1/7/92</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Seamstress</span>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <span style="font-size: 1.1em;">80</span>
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.1em;">McWilliams</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">?</span>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">213-70-3146A</span>	
17. INFORMANT <span style="font-size: 1.1em;">John L. Schlutter</span>		ADDRESS <span style="font-size: 1.1em;">3008 E. Baltimore St.</span>	
18. <span style="font-size: 1.1em;">412121</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <span style="font-size: 1.2em;">Hypertensive Cardiovascular Disease</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) _____	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">July 1967</span> 19____ to <span style="font-size: 1.1em;">Sept</span> 19 <span style="font-size: 1.1em;">1972</span> that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.1em;">Larry S. Tolley</span>		23B. DATE SIGNED <span style="font-size: 1.1em;">9-2-72</span>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS _____	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>	24B. DATE <span style="font-size: 1.1em;">9/5/72</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.1em;">Oak Lawn Cemetery</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Maryland</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">SEP 5 1972</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Audrey Whitman</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">John A. Moran, Inc.</span> ADDRESS <span style="font-size: 1.1em;">3000 E. Baltimore St. Baltimore, Md. 21224</span>	

Baltimore, Maryland

Oak Lawn Cemetery

9/21/75

Burial

George P. Schutter

Jan 1981

Sept

1975

D-5-15

Hyper tension (Major) Discharge

513-10-3144 John L. Schutter 3008 E. Baltimore St.

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Maryland

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3008 E. Baltimore Street

Baltimore

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Maryland

September 1, 1975

Long Green Nursing Home

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W.

F.

Zenatone

McWilliams

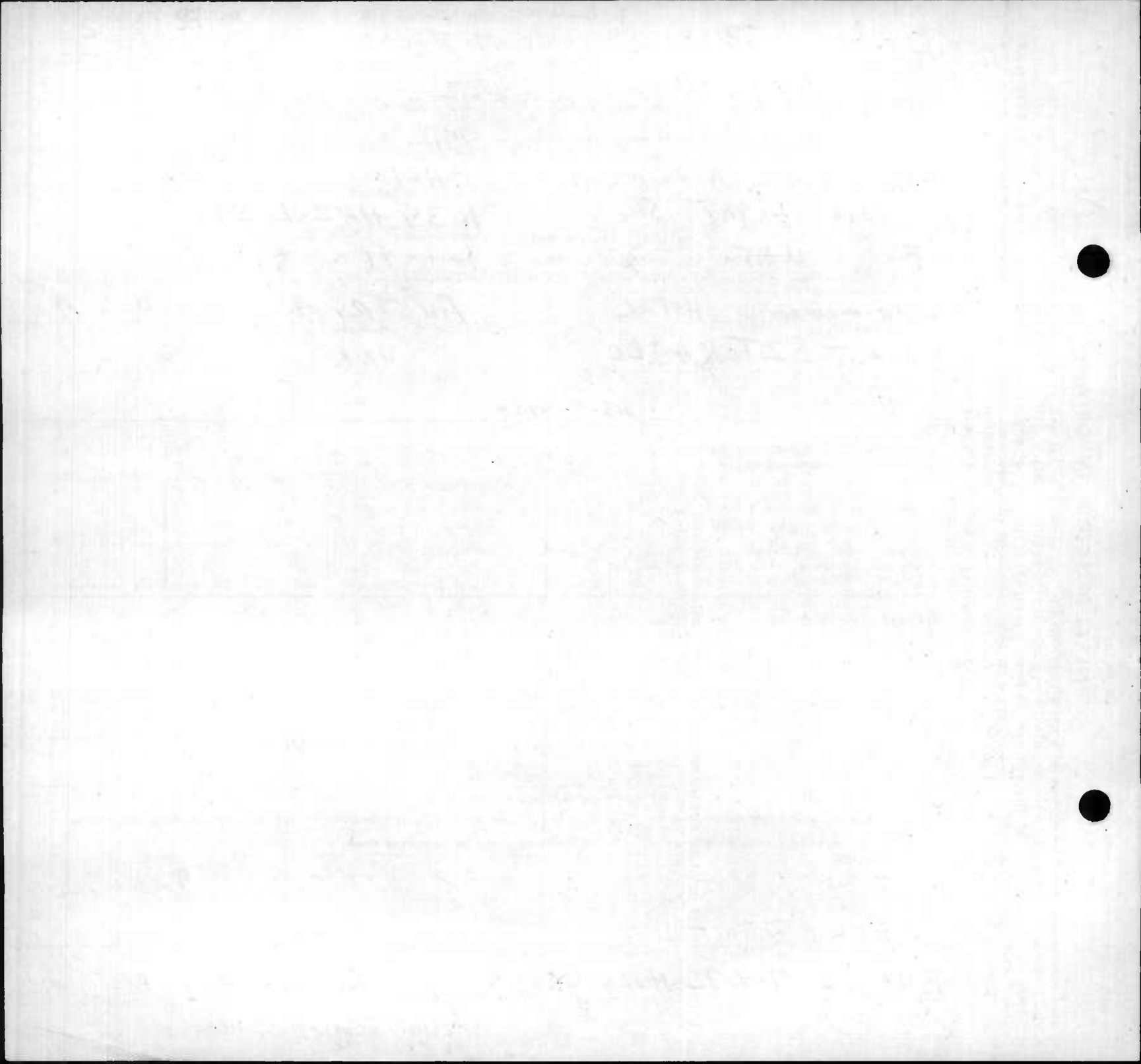
No

Anna M. Schutter

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08452	
72 08452				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ALEXANDRA KRAWCZUK</b>		2. DATE AND HOUR OF DEATH <b>9-1-72 5:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <b>HARBOR View Nursing Home</b>		C. CITY OR TOWN <b>BALTO.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ADDRESS OR LOCATION <b>70 1312 Light ST.</b>		E. STREET AND NUMBER <b>1634 HAZEL ST.</b>			
5. SEX <b>F</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-91</b>	9. AGE (In years last birthday) <b>81</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAR-woman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>		11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>	
13. FATHER'S NAME <b>Vincent SZTOKAJLO</b>		14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>245-01-4415A</b>		17. INFORMANT ADDRESS	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Anterior Sclerotic Cardiovascular Disease &amp; CHF</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Osteoarthritis, Heart</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Osteoarthritis, Heart</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>December 12</b> 19 <b>69</b> to <b>19</b> <b>72</b> and that (I) (we) lost saw the deceased alive on <b>September 1</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Peter H Rheinstein, MD</b>				23B. DATE SIGNED <b>9-3-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>PETER H. RHEINSTEIN, MD</b>				23D. ADDRESS <b>HARBOR VIEW CONVALESCENT CENTER</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9-4-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross</b>	
24D. LOCATION <b>Ritchie Hwy BALTO. MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>			
25B. NAME OF REGISTRAR <b>Friday, September 1, 1972</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Helen Funeral Home</b>			



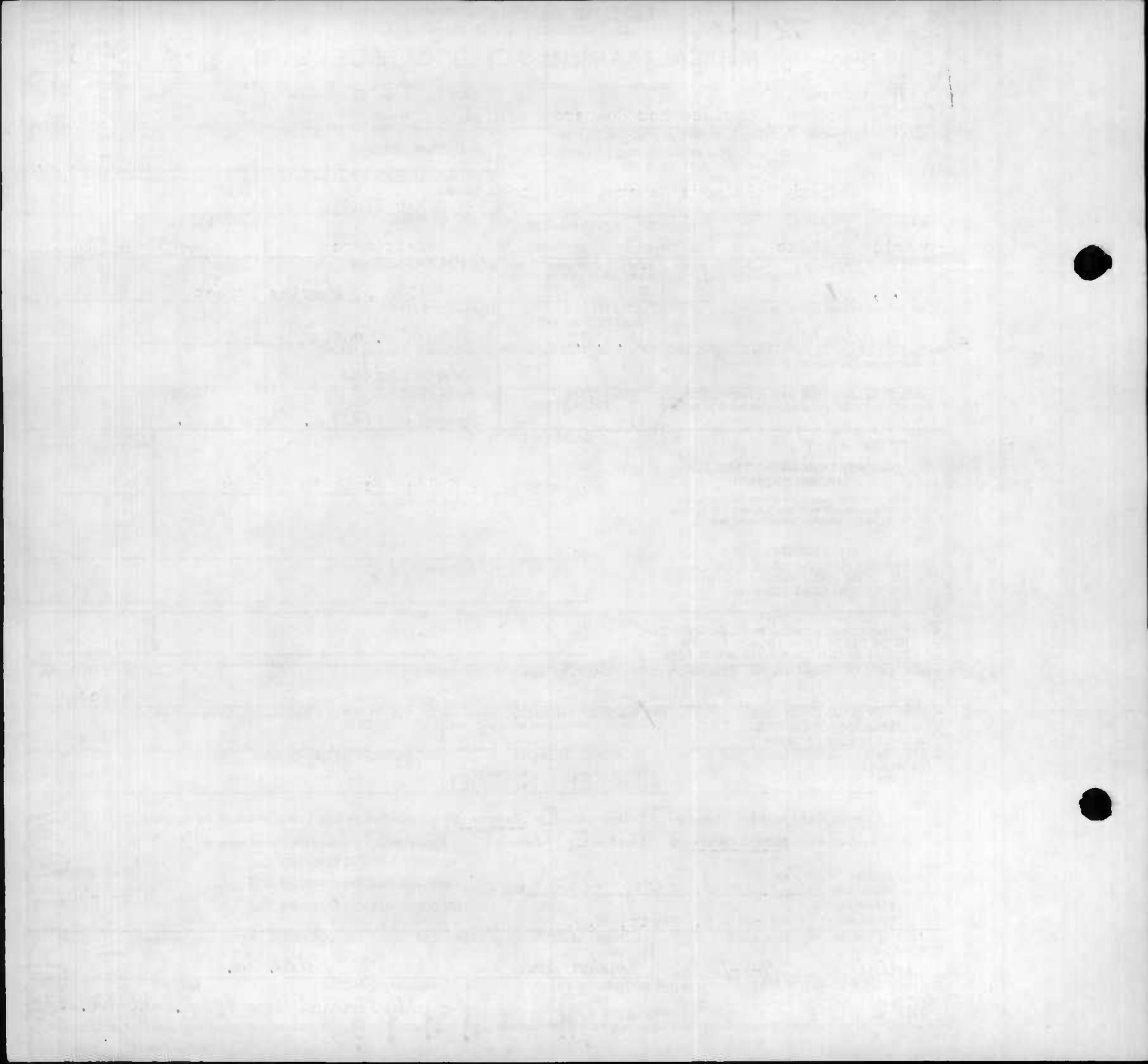
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 71-20188

REG. NO.

1. NAME OF DECEASED (Type or Print) Christopher Connors		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 9 Day 1 Year 72 Hour 5:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month 9 Day 1 Year 72 Hour 5:45 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2301	
9. DATE OF BIRTH 1971 Dec. 4, 1971		10. AGE (In years last birthday) 9	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Ronald W. Conner		15. MOTHER'S MAIDEN NAME Sharon Giles	
18. INFORMANT Parents		ADDRESS 1328 S. Charles St.	
19. 775X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Sudden death in infancy DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Marvin S. Platt M.D.</u> M.D. EXAMINER'S NAME (Type) Marvin S. Platt, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED 9-1-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 9-5-72	
24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR L. J. J. J.	
25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 130 E. Font Ave. 21230	

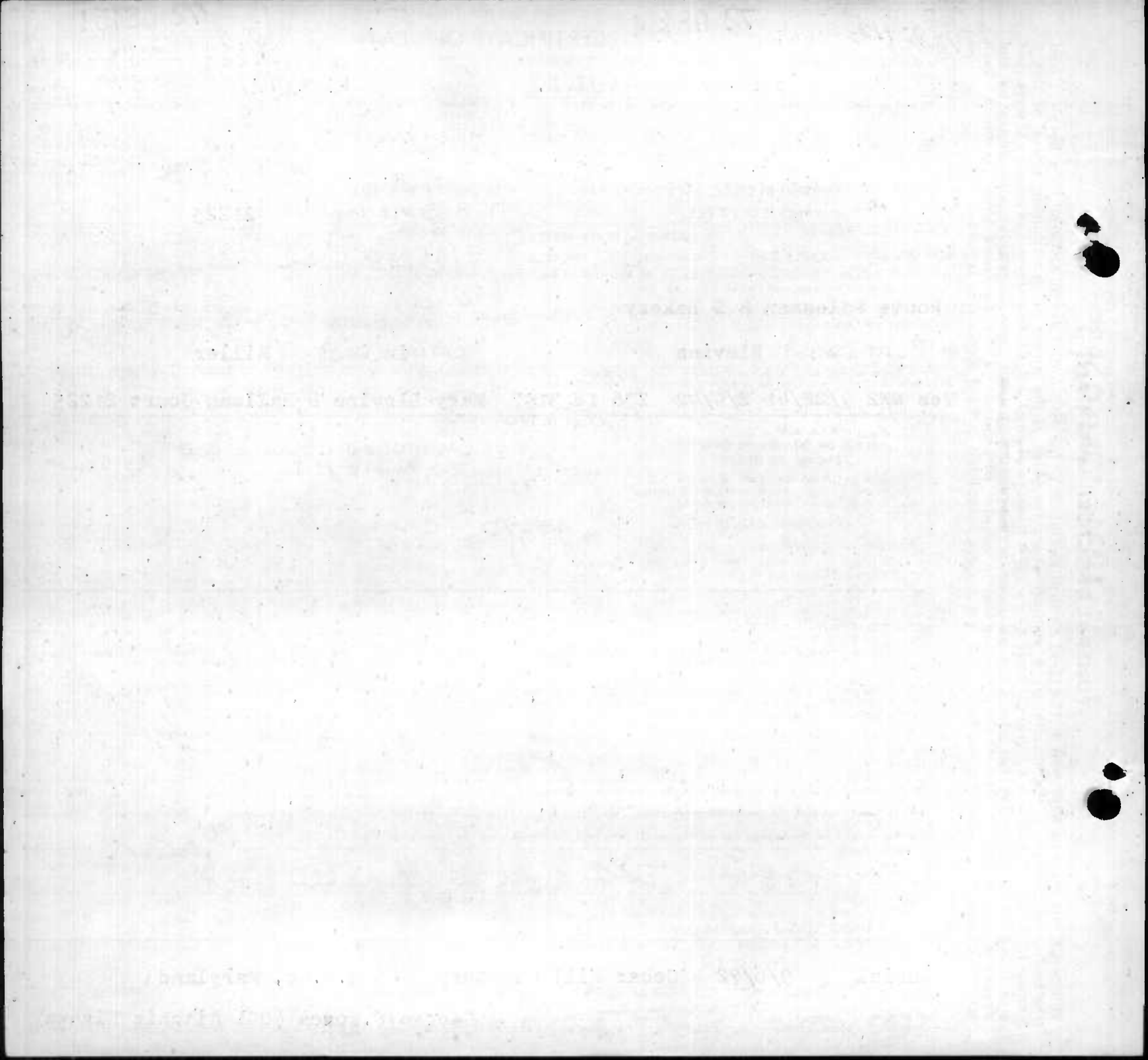


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08454	
BIRTH NO. 72 08454				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>BLEVINS PAUL I.</b>				2. DATE AND HOUR OF DEATH <b>9/3/72 5:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>AA</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>8 BALLMAN CT. 21225</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/20</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Route Salesman H S Bakery</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>W. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>BURT (Dec.) Blevins</b>				14. MOTHER'S MAIDEN NAME <b>CALLIA (Dec.) Miller</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW2 9/22/41 2/9/42</b>				16. SOCIAL SECURITY NO. <b>236 18 3197</b>		17. INFORMANT ADDRESS <b>Mary Blevins 8 Ballman Court 21225</b>	
18. <b>4/10/91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CARDIOGENIC SHOCK DUE TO ACUTE M.I.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD - C.H.F.</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>9/6/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>9/3/72</b> to <b>9/3/72</b> and that (I) <del>last</del> saw the deceased alive on <b>9/3/72</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>did not</del> view the body after death.							
23A. SIGNATURE <b>M. Koncanic M.D.</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>MIROSLAV KONCANIC, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/6/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A.A.Co, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Highway</b>	

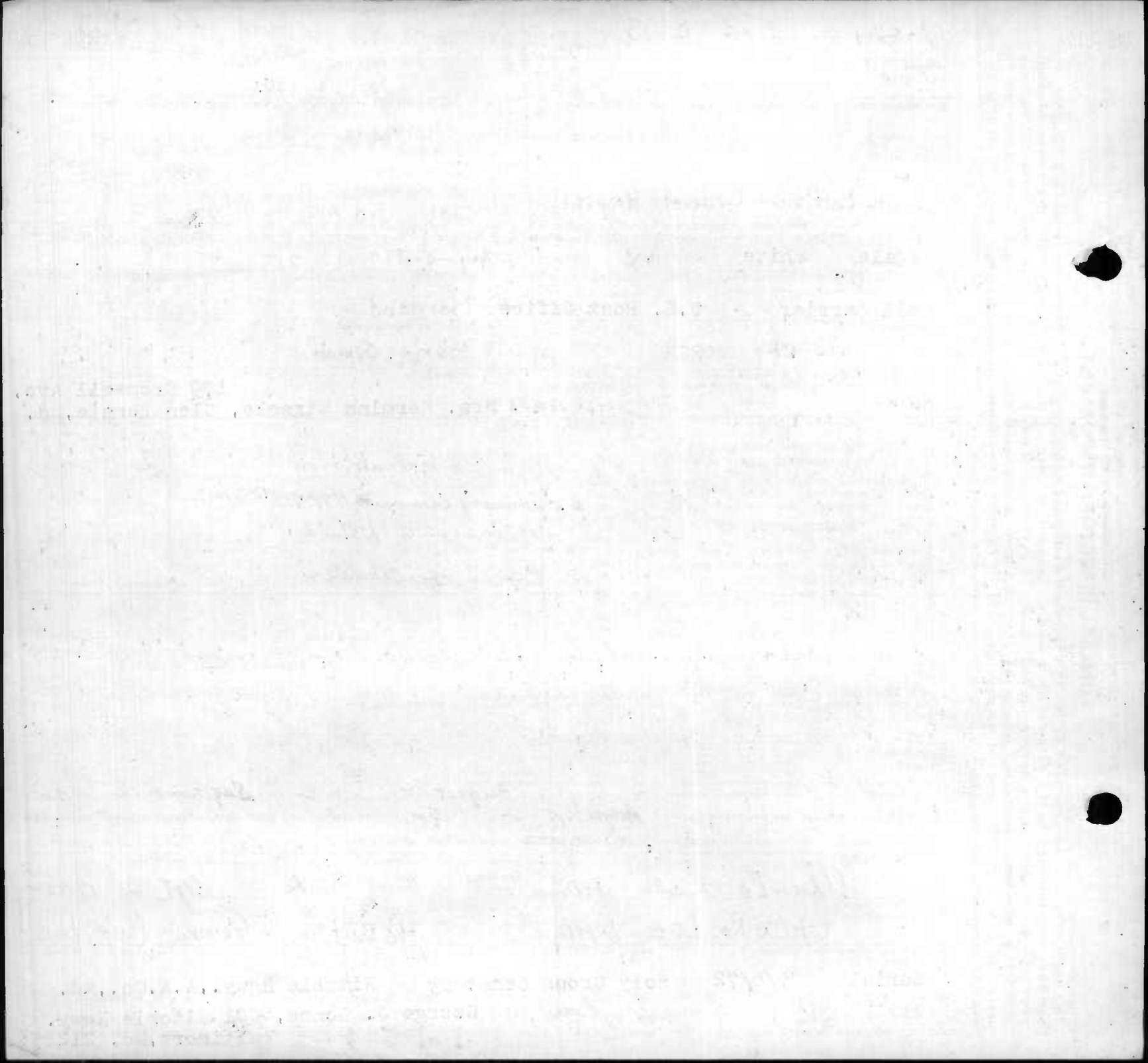




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08455		72 08455	
W-620				72 08455		72 08455	
BIRTH NO.				REG. NO.		STATE OF MARYLAND-DEPT	
1. NAME OF DECEASED (Type or Print) <b>Worch Herman J.</b>				2. DATE AND HOUR OF DEATH <b>Sept. 2, 1972 3:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>AA</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>201 3rd Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug-7-1897</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mail Carrier</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY WORCH</b>				14. MOTHER'S MAIDEN NAME <b>Marie, Simon</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-22-2676-A</b>		17. INFORMANT <b>Mrs. Hermina Stracke, Glen Burnie, Md.</b>			
18. <b>188 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>malnutrition</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. <b>2 months</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>malnutrition</b> DUE TO, OR AS A CONSEQUENCE OF: <b>pulmonary edema → Hypoproteinemia</b> (B) <b>Vesico-colic fistula</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Cancer of Bladder</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 5, 1972</b> to <b>September 2, 1972</b> , that (I) (we) last saw the deceased alive on <b>Aug Sept 2, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Uhun Ro. Lee MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Sept 2, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Uhun Ro LEE MD</b>				23D. ADDRESS <b>South Baltimore General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/6/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hgwy., A.A.Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Hgwy. Baltimore, Md. 21225</b>			



# FUNERAL DIRECTOR: IMPORTANT

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H-220		72 08456		CITY HEALTH DEPARTMENT		72 08456	
BIRTH NO.		72 08456		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>CHARLES L. HEACOCK JR</b>		2. DATE AND HOUR OF DEATH <b>8.30.72</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2551</b>	
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. <input checked="" type="checkbox"/> <b>MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b>		8. DATE OF BIRTH <b>12-27-1920</b>	
9. AGE (In years last birthday) <b>51 Yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES L. ST.</b>		14. MOTHER'S MAIDEN NAME <b>Maude E. Bramble</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 11</b>		16. SOCIAL SECURITY NO. <b>218-05-7252</b>	
17. INFORMANT <b>WILLIAM T ST. (Brother)</b>		18. ADDRESS <b>Balto. 21229</b>		19. DATE OF OPERATION <b>0</b>		20. AUTOPSY? (Yes or No) <b>0</b>	
21. TIME OF INJURY (Approx.) <b>185X I</b>		22. I certify that (I) (this hospital) attended the deceased from <b>8.28.1972</b> to <b>8.30.1972</b> , that (I) (we) last saw the deceased alive on <b>8.29.1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <b>M.Y. KHATTAK MD</b>		24. DATE SIGNED <b>August 30, 72</b>	
25. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		26. NAME OF REGISTRAR <b>Disney</b>		27. FUNERAL DIRECTOR <b>Hubbard Funeral Home Inc.</b>		28. ADDRESS <b>4107 Wilkens Ave.</b>	

6/29/73 - Letter from William T. Heacock, informant and brother of decedent.

*WTH*

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		72 08457		72 08457	
S-536		72 08457		72 08457	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO. 72 08457	
1. NAME OF DECEASED (Type or Print) <i>MRS. NONA KATHLEEN SNYDER</i>		2. DATE AND HOUR OF DEATH <i>8-30-92 5:30 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>BALTO</i> B. COUNTY <i>5300</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Hood Cres. Lutescent Home</i> <i>5313 Chesapeake Ave. - 28</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3206 BRIANT AVE</i>	
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-29-1902</i>	9. AGE (In years last birthday) <i>70</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bon Secours Convent</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
13. FATHER'S NAME <i>Harry Witzer</i>		14. MOTHER'S MAIDEN NAME <i>Bertha Thundledacher</i>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>217--22-7919</i>		17. INFORMANT ADDRESS <i>Kenneth L. Snyder, Sr., 2214 Smith Ave. 21227</i>	
18. <i>412.214250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i> <i>accident</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertension and</i> <i>ASCVD.</i> (C) <i>Diabetes mellitus</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>9-2-1972</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>SEP 3 1972</i>		23C. PHYSICIAN'S NAME (Type) <i>DR. RAFAEL H. MARIN</i>	
23D. PHYSICIAN'S ADDRESS <i>DR. AGNES MED CTR</i> <i>BALTO MD 21229</i>		23E. NAME OF REGISTRAR <i>[Signature]</i>		23F. FUNERAL DIRECTOR ADDRESS <i>Hubbard Funeral Home Inc. 4107 Wilkens Ave.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9-2-1972</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		24E. DATE OF DEATH BY HEALTH DEPT. <i>SEP 5 1972</i>		24F. NAME OF REGISTRAR <i>[Signature]</i>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

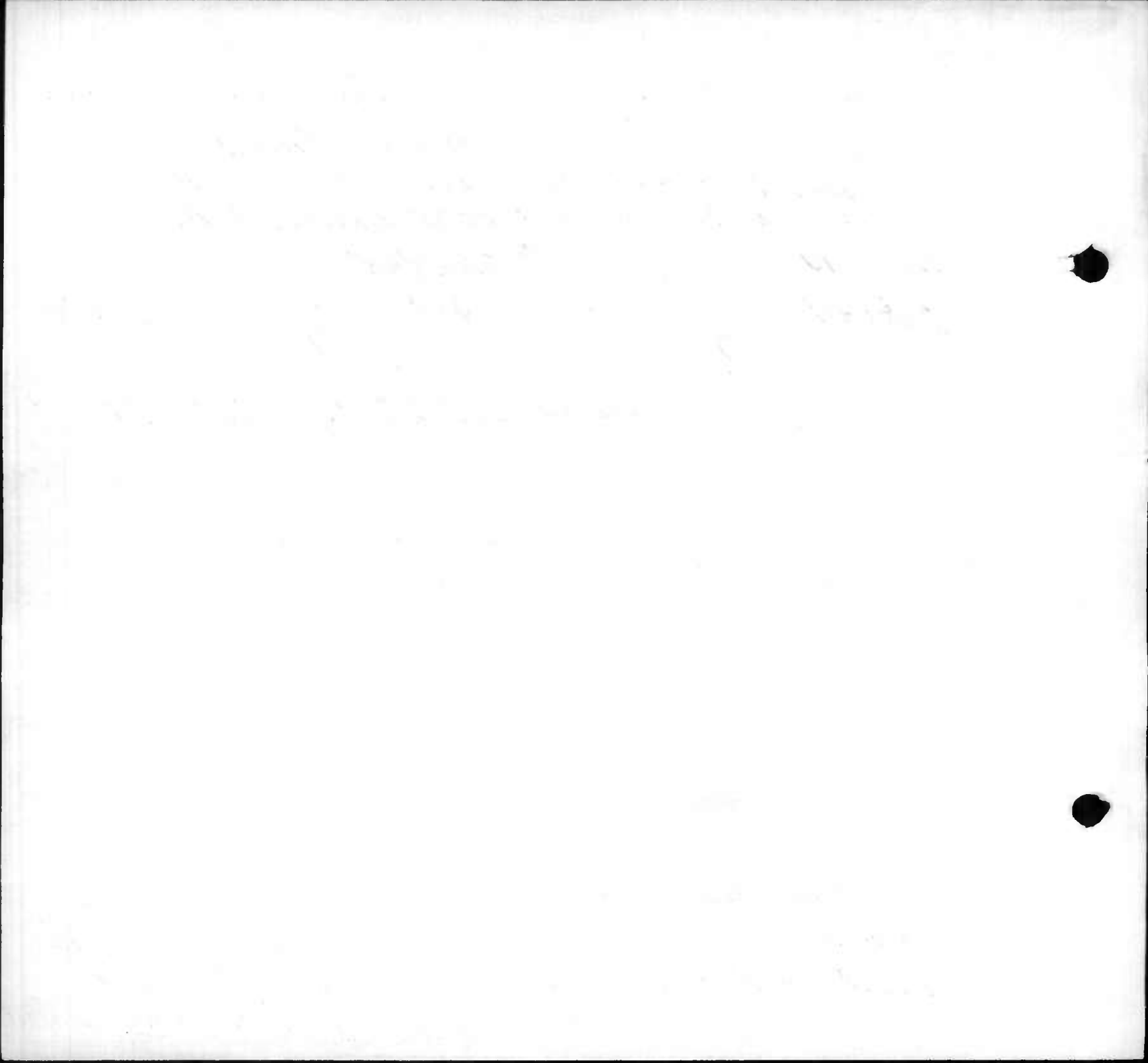
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08458	
72 08458		CERTIFICATE OF DEATH	
BIRTH NO. 0-640		STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <i>Jennie Carroll</i>		2. DATE AND HOUR OF DEATH <i>August 31st 1972 7:35 pm</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>34 Box Securus Hosp</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1302</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2401 Gutan Pl. Late dr. nursing</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/29/73</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Companion</i>		9. AGE (in years lost birthday) <i>99</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Martin Hanrahan</i>		14. MOTHER'S MAIDEN NAME <i>Ellen?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>318-14-7646</i>	
		17. INFORMANT ADDRESS <i>Alice Keller 8506 Chestnut Oak 21234</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>arteriosclerotic cardiovascular dis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. DATE OF OPERATION <i>8</i>		20. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>William E. Johnson MD</i>		23B. DATE SIGNED <i>8-31-72</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>9/2/72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. City, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 5 1972</i>		25B. NAME OF REGISTRAR <i>Lidney Johnson</i>	
25C. FUNERAL DIRECTOR <i>William E. Johnson</i>		ADDRESS <i>8521 Loch Raven</i>	

1970 - Adm. From Bolton Hill N.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 08459</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 08459</span>
1. NAME OF DECEASED (Type or Print) <u>Spencer Henry</u>		2. DATE AND HOUR OF DEATH <u>8-30-72</u> <u>8:40 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Dukeland Nursing Home</u> <u>1501 N. Dukeland St.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1004</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1038 Brentwood Ave.</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/98</u>	9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u>		
14. MOTHER'S MAIDEN NAME <u>?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>248-24-0586</u>		17. INFORMANT <u>Dukeland Nursing Home</u> ADDRESS <u>1501 N. Dukeland St.</u>		
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CVA - (L) HEMIPLEGIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>SEIZURE DISORDER</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Phillip E. Burd</u> M.D. DEGREE		23B. DATE SIGNED <u>8/30/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Phillip E. Burd M.D.</u> DEGREE
23D. ADDRESS <u>4200 Edmondson Ave. Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>9/5/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. County Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>		25B. NAME OF REGISTRAR <u>Shirley H. Hester</u>		25C. FUNERAL DIRECTOR <u>Locks Funeral Home</u> ADDRESS <u>1347 N. Central Ave.</u>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RUDOLPH BARNES</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 2016 E. Lafayette Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 1, 1972 4:30 P.M.</b>	
6. SEX <b>Male</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>Negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>9/21/52</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>19</b>		E. STREET AND NUMBER <b>2016 E. Lafayette Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Balt. Md</b>		13. FATHER'S NAME <b>FRANK BARNES</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		15. MOTHER'S MAIDEN NAME <b>Nolene Knight</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		17. SOCIAL SECURITY NO.	
19. <b>304.91</b>		18. INFORMANT <b>Per Frank Barnes 2016 E. Lafayette Ave</b>	
CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Narcotic Addiction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) <b>22D. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22E. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9/2/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/5/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Audrey H. [illegible]</b>	
25C. FUNERAL DIRECTOR <b>Joseph G. [illegible]</b>		ADDRESS <b>1304 N. Central St</b>	

11-20-1972 - Completion of cause of death on a pending medical Examiner Death  
Certificate - Peter Lipkovic, M.D. HRS

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-623		72 08461		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08461	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BARKSDALE, Otha				2. DATE AND HOUR OF DEATH 9/1/72 7:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Indiana B. COUNTY C. CITY OR TOWN Fort Wayne D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 716 MADISON ST			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/05	9. AGE (In years last birthday) 67	11. BIRTHPLACE (State or foreign country) Va		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY Retired		12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME JENNINGS BARKSDALE				14. MOTHER'S MAIDEN NAME ELLA Oliver			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 306-03 91328		17. INFORMANT CARRIE HOBARD		ADDRESS 1407 KENHILL AVE	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
				(B) PROBABLE MI		1 hour	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/1 19 72 to 9/1 19 72 that (I) (we) last saw the deceased alive on 9/1 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE W. Michael Tucker M.D.				23B. DATE SIGNED 8/1/72			
23C. PHYSICIAN'S NAME (Type) W. Michael Tucker, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 9/3/72		24C. NAME OF CEMETERY or CREMATORY LINDEN WOOD CEM.		24D. LOCATION (City, town, or county) (State) FORT WAYNE, INDIANA	
25A. DATE REC'D BY HEALTH DEPT. SEP 5 1972		25B. NAME OF REGISTRAR Sidney Johnson		25C. FUNERAL DIRECTOR Joseph B. Locks		ADDRESS 1304 N. Central St	

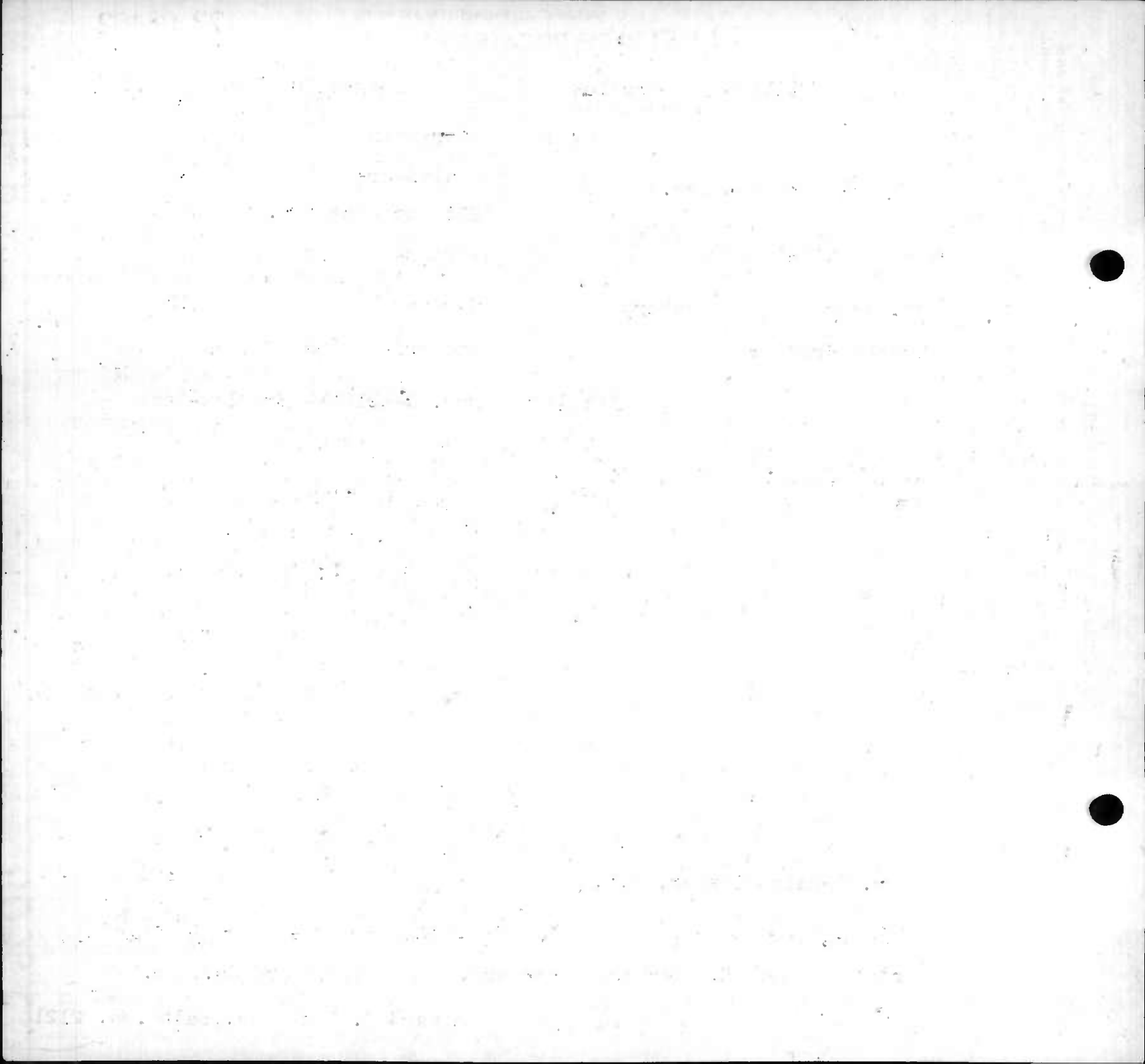


THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

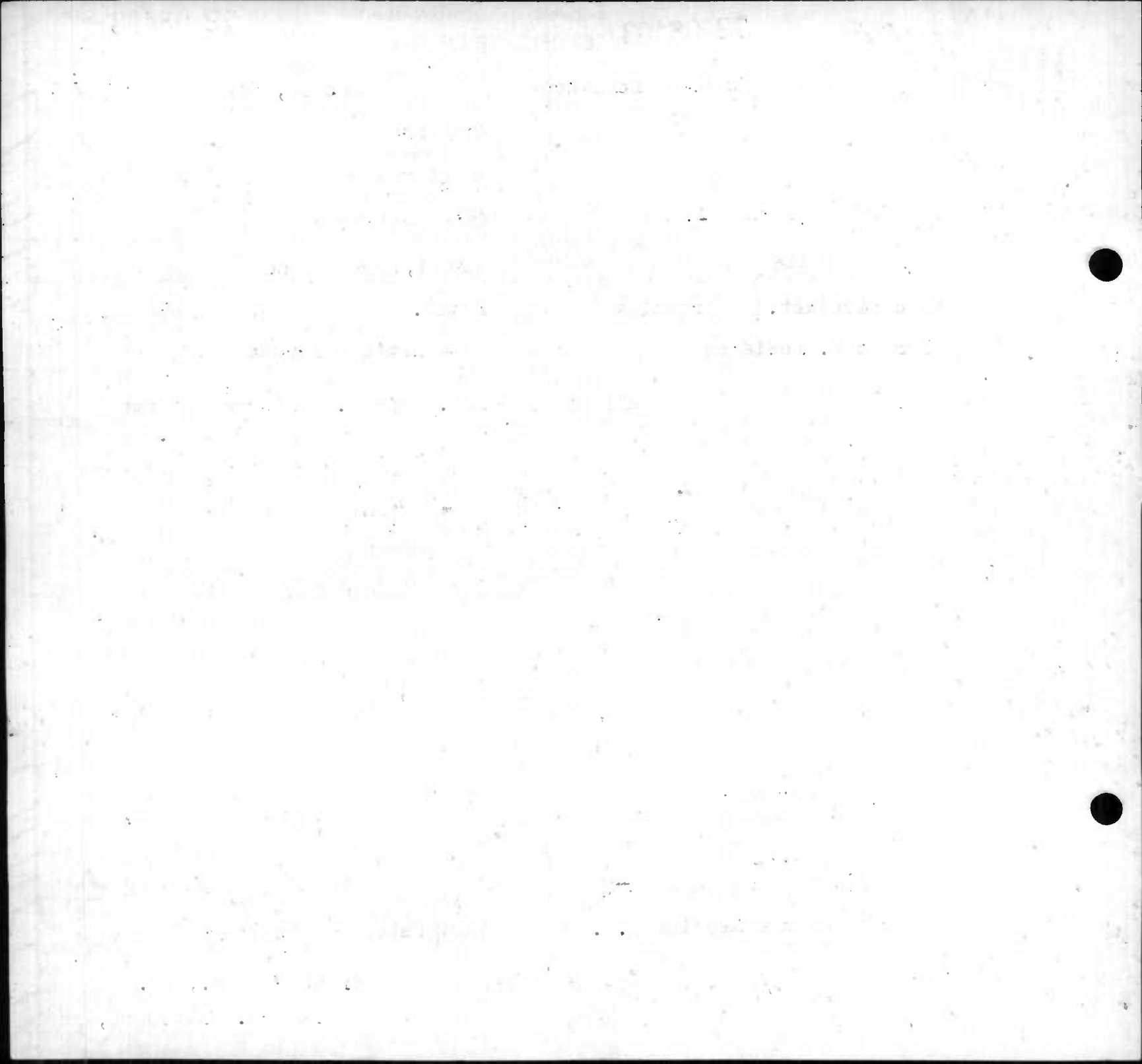
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08462
72 08462 CERTIFICATE OF DEATH				STATE OF MARYLAND - DECEASED
BIRTH NO. <b>B-634</b>		1. NAME OF DECEASED (Type or Print) <b>William Bredlow</b>		
2. DATE AND HOUR OF DEATH <b>August 30, 1972 10:30 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
<b>3221 Woodhome Ave.</b>		A. STATE <b>Maryland</b>		
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>5/7/1905</b>		9. AGE (In years last birthday) <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Baker</b>
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Gustav Bredlow</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Mink</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215102186</b>		17. INFORMANT <b>Margaret Mrs. Charlotte Bredlow-Same</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>acute Pulmonary Edema</b>		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension cardiovascular Disease - Ch failure</b>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Multiple Myeloma</b>		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1965</b> to <b>Aug 30, 1972</b> that (I) (we) last saw the deceased alive on <b>Aug 30, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Dr. Donald Mintzer, M.D.</b>				23B. DATE SIGNED <b>Sept 11/1972</b>
23C. PHYSICIAN'S NAME (Type) <b>DONALD MINTZER</b>				23D. ADDRESS <b>3009 EVERGREEN AVE BALTO MD 21214</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/2/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery,</b>
24D. LOCATION (City, town, or county) <b>Baltimore Co., Md.</b>		25A. DATE RECD BY HEALTH DEPT. <b>SEP 5 1972</b>		
25B. NAME OF REGISTRAR <b>Sidney H. Hooton</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc., Balto. Md. 21214</b>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 08463</b>	
L-152 72 08463				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Joseph Charles LoBianco</b>		2. DATE AND HOUR OF DEATH <b>August 31, 1972</b> <b>9 P.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>2812 Inglewood Ave</b>		A. STATE <b>Maryland</b>		B. COUNTY <b>2757</b>	
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2812 Inglewood Ave</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1906</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive(Ret.)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Charles J. LoBianco</b>			14. MOTHER'S MAIDEN NAME <b>Concetta Spicuzza</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 09 9314</b>		17. INFORMANT <b>Mrs. Anne M. LoBianco</b>	
				ADDRESS <b>Same</b>	
18. <b>410.91</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>					
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Severe A.S.C.V.D.</b>					
(C) <b>Previous Myocardial Infarctions</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>Dr. John J. Messina</b> attended the deceased from <b>5-10-72</b> 19 to <b>6-2-72</b> 19, that <b>Dr. (ve)</b> last saw the deceased alive on <b>6-2-72</b> 19 and that in <b>Dr. (ve)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>Dr. (ve)</b> (did not) view the body after death.					
23A. SIGNATURE <b>John J. Messina M.D.</b>				23B. DATE SIGNED <b>9-1-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John J. Messina M.D.</b>				23D. ADDRESS <b>7401 Osler Dr Towson Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/5/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>			
25B. NAME OF REGISTRAR <b>Sidney H. Weston</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Baltimore, Md</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08464

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)RICHARD ~~WATERS~~ CRAIGE2. DATE  
OF  
DEATHKnown ☒ Estimated ☐Month Day Year  
August 30, 1972Hour  
12:40 P.M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF  
HOSPITAL  
OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 University Hospital

3. DATE  
PRONOUNCED DEADMonth Day Year  
August 30, 1972Hour  
12:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6600

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Hyattsville

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11-23-1937

10. AGE (In years  
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2010 Lewisdale Drive

11. BIRTHPLACE (State or foreign country)

MISSOURI

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DON W. CRAIG

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retail Manager

14B. KIND OF BUSINESS OR INDUSTRY

Montgomery wards

15. MOTHER'S MAIDEN NAME

BETTY BAKER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

1956-1960

17. SOCIAL  
SECURITY NO.

490-38-7635

18. INFORMANT

ADDRESS

Don Craig 6212 Ruatan St. Berwyn, Hgts

19.

E814.7

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Cerebro-cranial injuries

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

Highway

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Rte 50

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

8-30-72

11:45 A.M.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject was getting out of car on  
shoulder of road when struck by

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

tractor-trailer

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Marvin S. Platt, MD.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 31, 1972

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-2-72

24C. NAME of CEMETERY or CREMATORY

George Washington Cemetery

24D. LOCATION (City, town, or county)

Hyattsville, MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

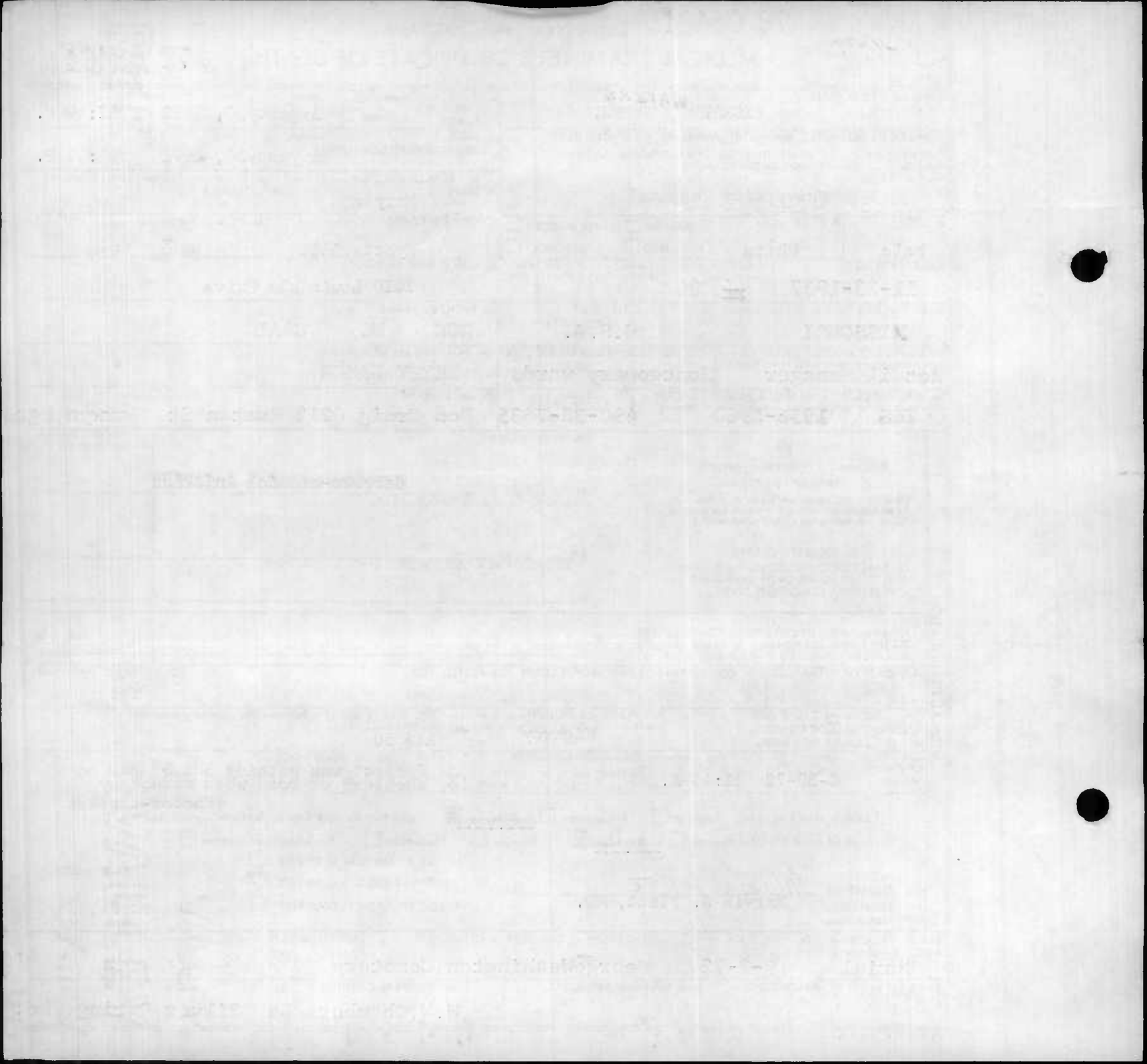
SEP 5 1972

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

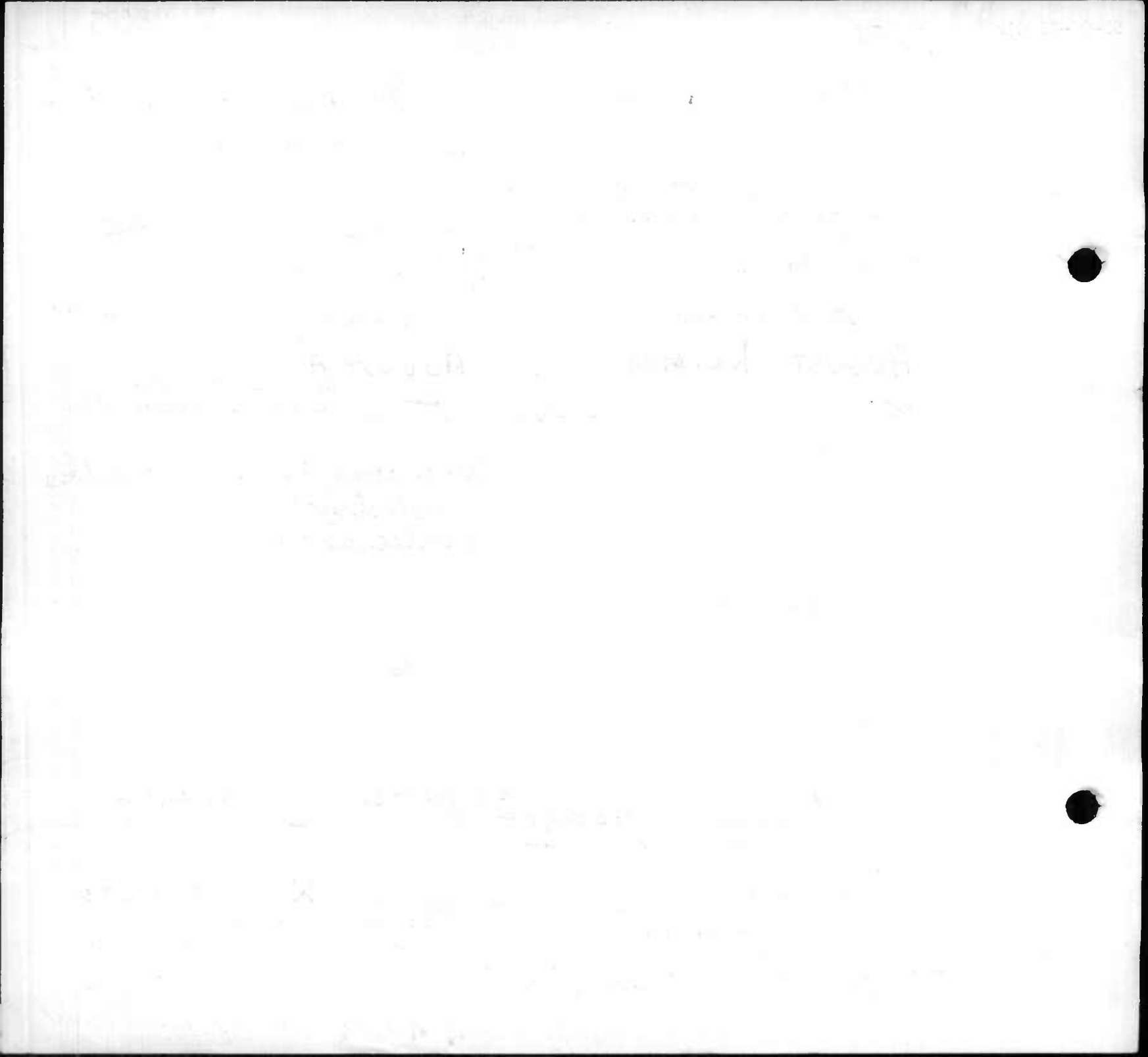
W.W. Chambers Co. Silver Spring, Md.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

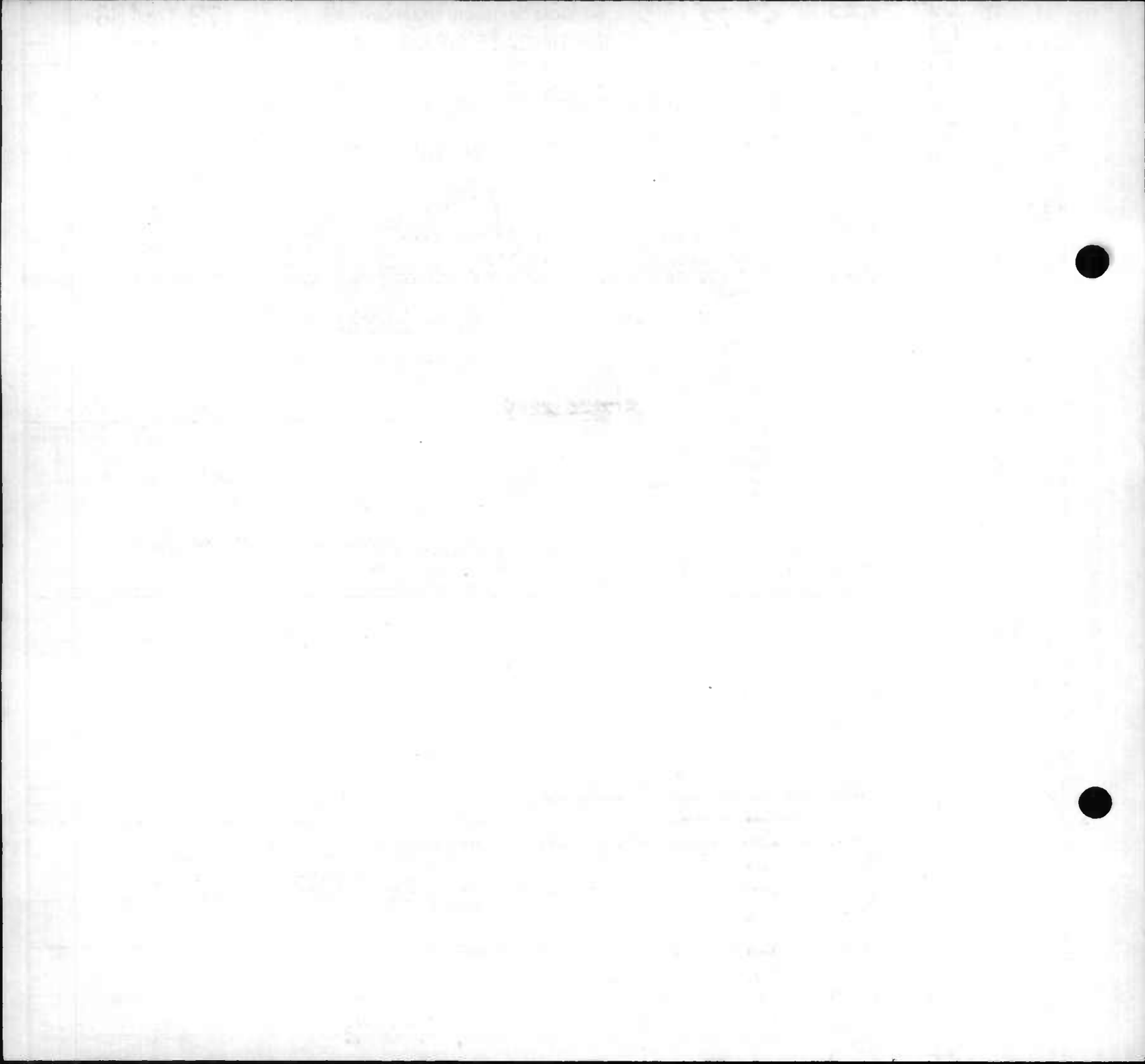
K-450		72 08465		BALTIMORE CITY HEALTH DEPARTMENT		72 08465	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>MARIE AKLIMM</b>				2. DATE AND HOUR OF DEATH <b>August 31-72 17:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2605</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE CITY Hospitals</b> <b>4940 Eastern Avenue Baltimore, Maryland</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>Caucasian</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>9/12/90</b>		9. AGE (In years last birthday) <b>81</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>				11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>AUGUST KLIMM</b>				14. MOTHER'S MAIDEN NAME <b>AUGUST A</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>178-22-8064</b>		17. INFORMANT <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>	
18. <b>1977-71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <b>Carcinoma of liver (metastatic).</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>source undet</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of liver (metastatic).</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>29 Jul 72</b> 19 to <b>31 Aug 72</b> 19 that (I) (we) last saw the deceased alive on <b>30 Aug 72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Salazar, M.D.</b>				23B. DATE SIGNED <b>31 Aug 72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Salazar, M.D.</b>				23D. ADDRESS <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>9/2/1972</b>		24C. NAME of CEMETERY or CREMATORY <b>FIRST UNITED EVANGELICAL CHURCH CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE CITY, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <b>Shirley Johnson</b>		25C. FUNERAL DIRECTOR <b>Walter Linfer Rodley, Duval, MD</b>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-453		72 08466		BALTIMORE CITY HEALTH DEPARTMENT		72 08466	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Bland, Joseph E.</u>				2. DATE AND HOUR OF DEATH <u>9-1-72 7:26 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Providence Hospital Inc.</u>				A. STATE <u>Maryland</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore, MD.</u>				B. COUNTY <u>Baltimore</u>			
5. SEX <u>M</u>				6. RACE <u>Black</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12-8-31</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (in years last birthday) <u>40</u>			
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD</u>			
13. FATHER'S NAME <u>GEORGE E. BLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>VIRGINIA HAMLETT</u>			
16. SOCIAL SECURITY NO. <u>217-26-2289</u>				17. INFORMANT <u>GERALDINE SINGLETON</u>			
18. <u>23 0.01 + 157.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Renal failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ca of pancreas, Diabetic</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>cirrhosis of liver, Chronic cholestasis</u> (C) <u>Renal failure</u>			
19A. DATE OF OPERATION <u>8-15-72</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstructive Taudie</u>			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Willie Brooks, MD</u>				23B. DATE SIGNED <u>9-1-72</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>9-6-72</u>			
24C. NAME of CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>				24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 5 1972</u>				25B. NAME OF REGISTRAR <u>Andrew M. Hopton</u>			
25C. FUNERAL DIRECTOR <u>WM. C. MARCH</u>				ADDRESS <u>928 E. North Ave</u>			



L-550

72 08467

STATE OF MARYLAND-DIRECT  
BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08467

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Willie (Lemoy) M. Lemmon

2. DATE  
OF DEATHKnown ☒ Estimated ☐

Month 8 Day 31 Year 72

Hour 10:04 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month 8 Day 31 Year 72

Hour 10:04 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY 805

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2-7-57

10. AGE (In years  
last birthday) 15If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

1716 E. 25th Street

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Willie M. Lemmon Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosa Montgomery

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Rosa Durante 1716 E. 25th Street

19. E9701X

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of neck  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIBUTING  
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)  
Street22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?N.W. Cor. of alley beside 1850 N. 802  
Collington Ave.22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.) 8 31 72 9:40 P. M.22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

allegedly  
shot by policeman

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)W P Mulloy M.D.  
William P. Mulloy, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-1-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

9-6-72

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

Manning, S.C.

(State)

25A. DATE REC'D BY HEALTH DEPT.

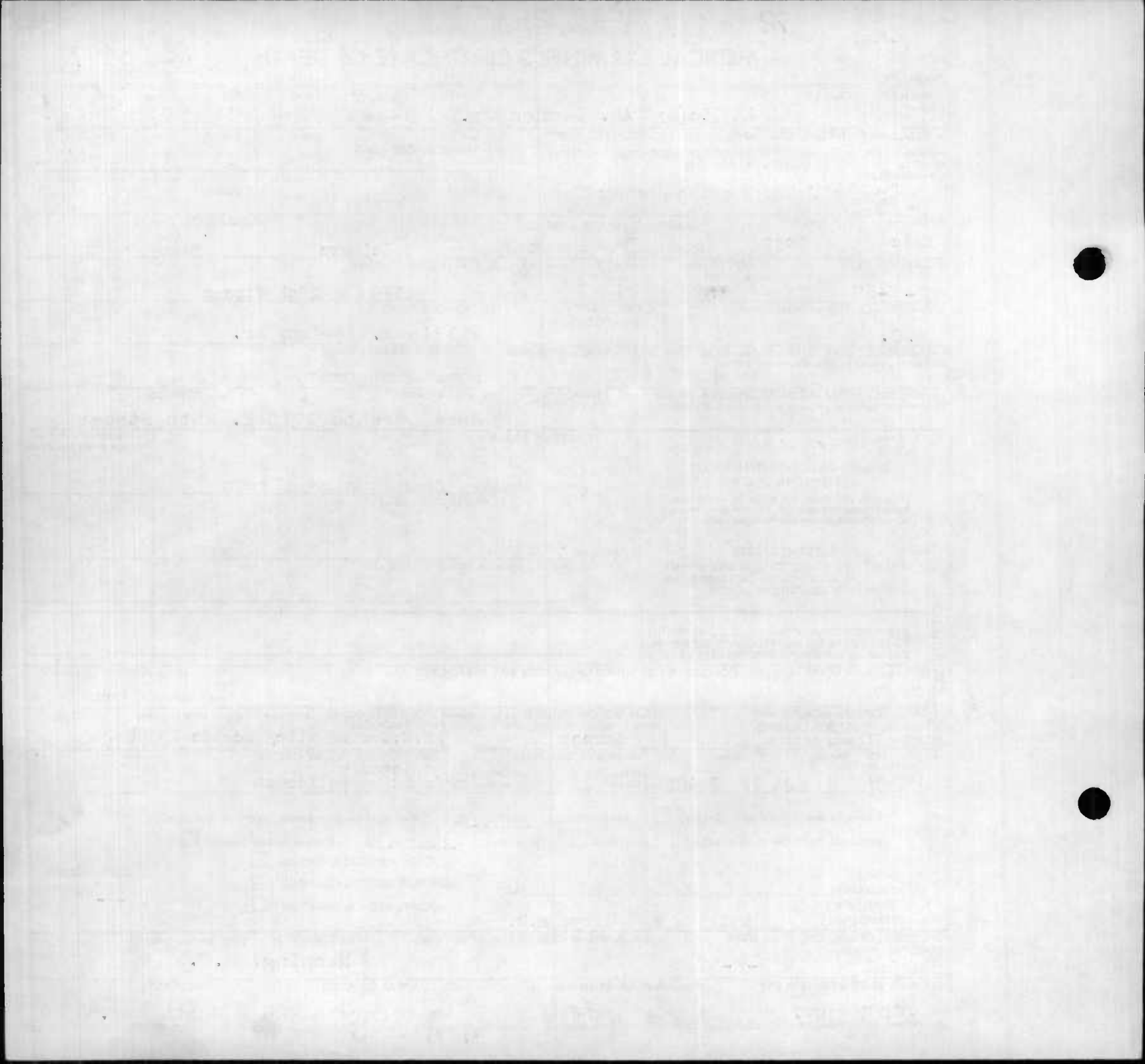
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SEP 5 1972

Wm C. March 928 E North Ave.

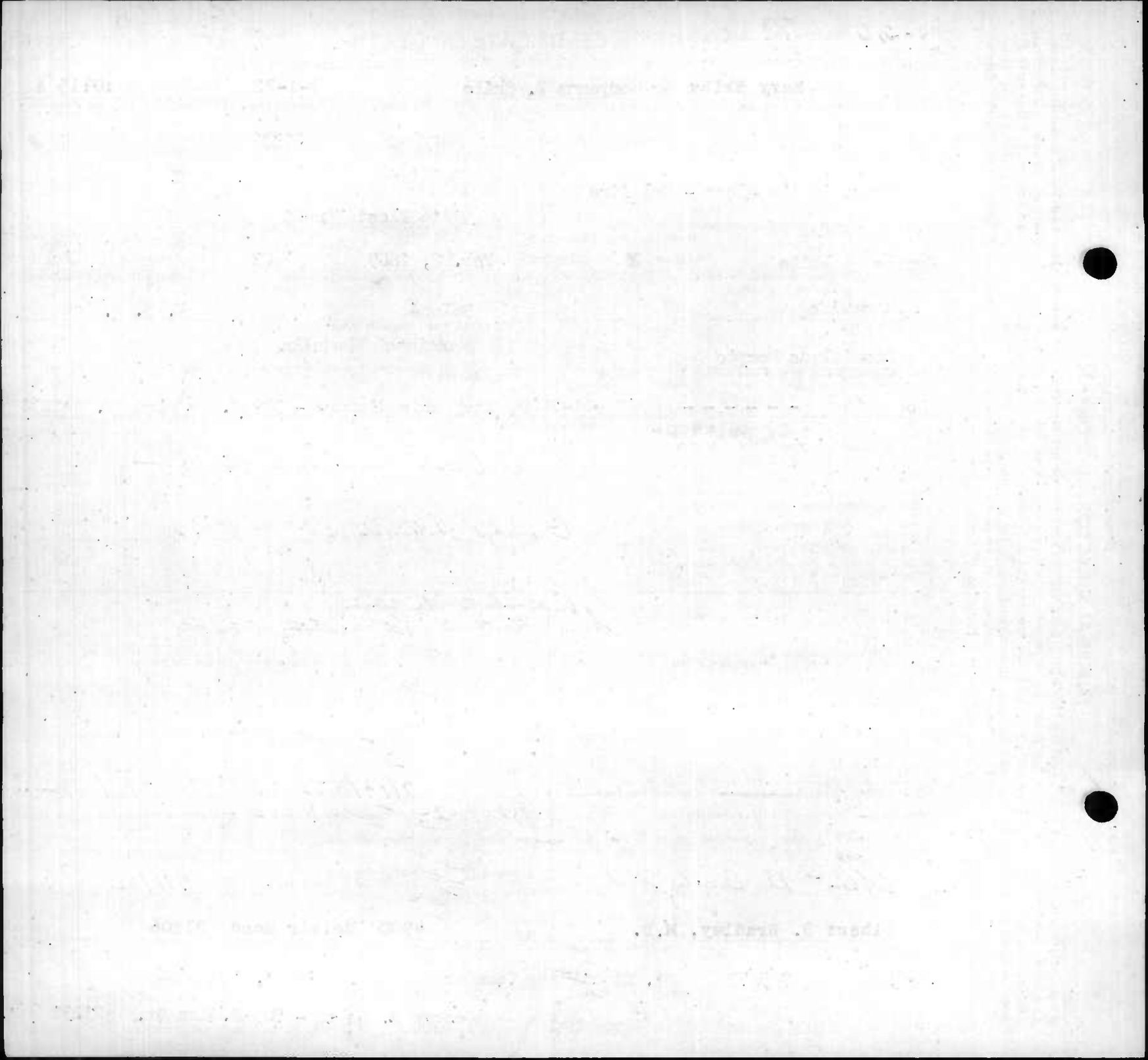


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 08468</span>
S-210 72 08468				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Mary Skiba or Maryanna K. Skiba		9-1-72 10:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
90 House in the Pines - Bel Aire		Maryland #21231 203		
		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER		
		1816 Fleet Street		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 2, 1889	83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife				Poland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Stanislaus Koryto		Marcinna Pudulka		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No		219-01-9229		Stephanie Ciapura - 309 S. Madeira St. #21231
18. <span style="font-size: 1.5em;">436.9 I</span>		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		Acute cerebrovascular accident -		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Grand's Arteriosclerosis		
II		(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic Heart Disease; Senile osteoarthritis; Post-traumatic stress		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7/19/1972 to 9/1/1972, that (I) (we) last saw the deceased alive on 8/20/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
Albert B. Bradley				9/1/72
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Albert B. Bradley, M.D.		4900 Belair Road 21206		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Burial		9/5/72		St. Stanislaus Cemetery
				Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
SEP 5 1972		George A. Weber		705 S. Ann St. #21231

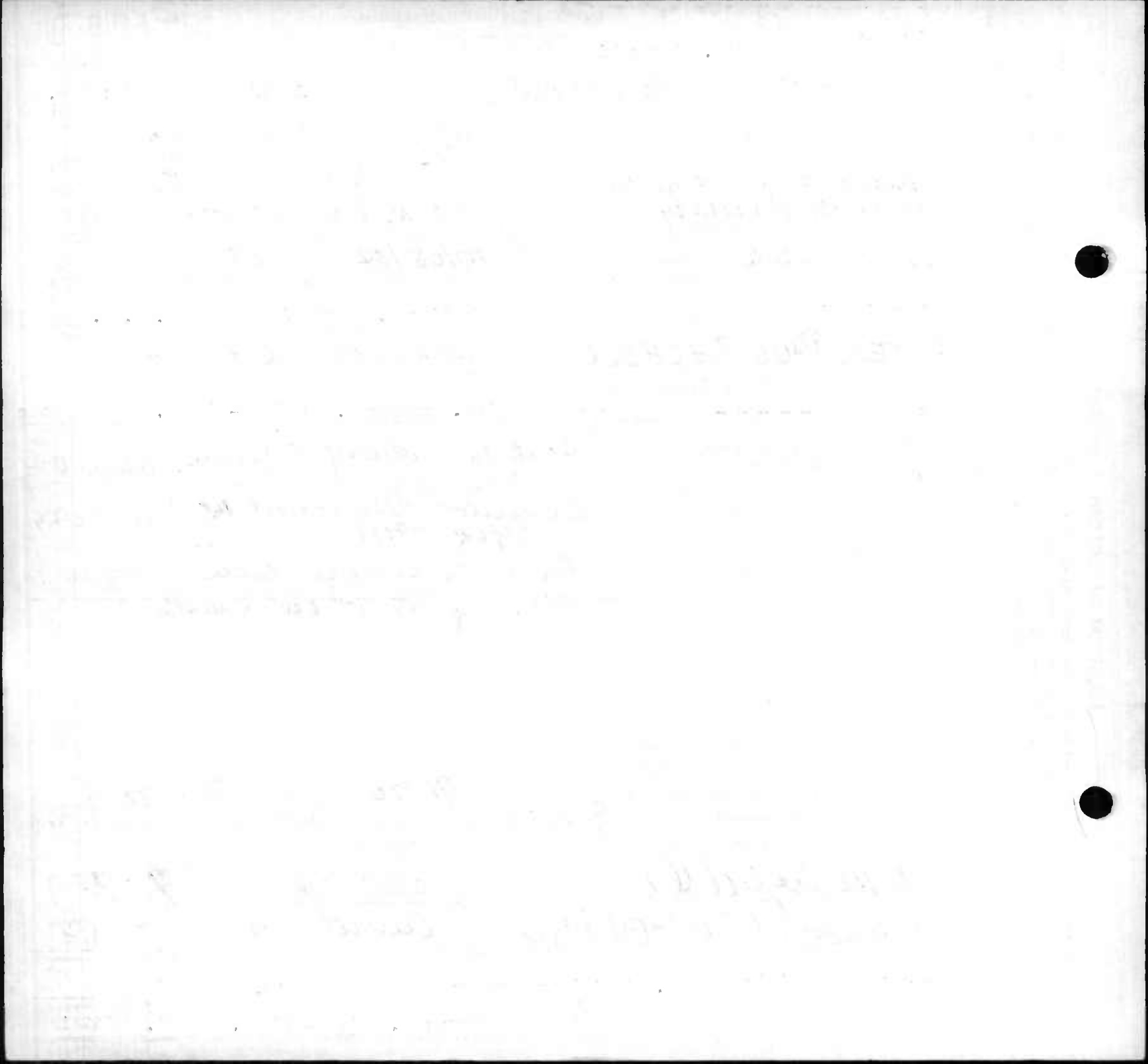




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-220 72 08469		BALTIMORE CITY HEALTH DEPARTMENT		72 08469	
BIRTH NO. Ronald G. Piechocki		REG. NO. 72 08469		STATE OF MARYLAND - DHMH	
1. NAME OF DECEASED (Type or Print) <b>PIECHOCKI, Mr RONALD</b>		2. DATE AND HOUR OF DEATH <b>9/2/72 10:00 a. m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home Hospital 100 North Broadway</b>		C. CITY OR TOWN <b>city.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>603 N. LINWOOD AV. 21205</b>					
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/08/34</b>	9. AGE (In years last birthday) <b>37</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>PETER PAUL PIECHOCKI</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES SCHMIDT</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Mrs. Frances C. Schmidt - 603 N. Linwood Ave</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Extensive myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Brain Damage due to Meningitis at age 18 months.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Brain Damage due to Meningitis at age 18 months.</b>		(C) <b>Brain Damage due to Meningitis at age 18 months.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>9/1/72</b> 19 to <b>9/2/72</b> 19		that (I) (we) last saw the deceased alive on <b>9/2/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Walter A. Imbrogliatti</b>		23B. DATE SIGNED <b>9/2/72</b>		23C. PHYSICIAN'S NAME (Type) <b>WALTER A. IMBROGLIATTI</b>	
23D. ADDRESS <b>Church Home Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/5/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>	
25B. NAME OF REGISTRAR <b>George A. Weber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George A. Weber - 705 S. Ann St. #21231</b>			



72 08470

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08470

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EMMA LFOUBLE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>September 2, 1972 4:25 A.M.</b>	
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>July 5, 1899</b>		10. AGE (In years last birthday) <b>73</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Balto. City</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired from Social Security</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>213-42-4106</b>	
15. MOTHER'S MAIDEN NAME <b>Emmeline Hare</b>		18. INFORMANT ADDRESS <b>Mr. C. Roland Fowble Baltimore, Md.</b>	
19. <b>E812.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Multiple Injuries</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>22</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street (5)</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>8-25-72 11:10 P. m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Greenspring Ave. 790 ft. N. of Rte. 695</b>		22F. HOW DID INJURY OCCUR? <b>Passenger in auto-auto collision</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>9/2/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Sept. 5, 72</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. Peters Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Millers, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 5 1972</b>		25B. NAME OF REGISTRAR <i>Sidney Winston</i>	
25C. FUNERAL DIRECTOR <b>Eline Funeral Home</b>		ADDRESS <b>Reisterstown, Md. 21136</b>	

75-1570

14

William T. Jackson

USA

Chief, City

Executive Order

Notified from United Security

100-43-110 Mr. C. Robert Jackson - Baltimore, Md.

No

Telephone Number

*Handwritten signature*

Chief, City

Baltimore, Md.

Chief, City

July 2, 1950

Chief, City

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08471	
S-552 72 08471				STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print)		SIMONS, LONEY MACK		2. DATE AND HOUR OF DEATH September 3, 1972 2:55 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		Maryland Baltimore	
6. CITY OR TOWN		Reisterstown		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
8. STREET AND NUMBER		Rt. Saffel Rd.			
9. SEX	10. RACE	11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	12. DATE OF BIRTH	13. AGE (in years last birthday)	14. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-9-10	62	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY		17. CITIZEN OF WHAT COUNTRY?	
Farm Care-taker				U. S. A.	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME			
Wallace B. Simons		Nannie Andrews			
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		21. SOCIAL SECURITY NO.		22. INFORMANT	
Yes 3-10-44 to 1-16-46		216-16-5602		Records V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218	
23. CAUSE OF DEATH		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Unk	
2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF:		Unk	
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)			
25. MEDICAL CERTIFICATION		26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED	
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
31. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		33. HOW DID INJURY OCCUR?	
34. I certify that (X) (this hospital) attended the deceased from September 2, 1972 to September 3, 1972, that (X) (we) last saw the deceased alive on September 3, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.		35. SIGNATURE		36. DATE SIGNED	
Katsuzo Fujita		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		9/3/72	
37. PHYSICIAN'S NAME (Type)		38. ADDRESS		39. DATE	
KATSUZO FUJITA, M.D.		V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			
40. BURIAL CREMATION, REMOVAL (Specify)		41. DATE		42. NAME OF CEMETERY or CREMATORY	
Burial		Sept. 5, 72		Evergreen Memorial	
43. DATE REC'D BY HEALTH DEPT.		44. NAME OF REGISTRAR		45. FUNERAL DIRECTOR	
SEP 5 1972		Eline Funeral Home		Reisterstown, Md. 21136	

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Approved by Medical Examiner 8/1/72  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-525		72 08472		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08472	
BIRTH NO.		72 08472		CERTIFICATE OF DEATH		STATE OF MARYLAND-DEMH	
1. NAME OF DECEASED (Type or Print) RICHARD J. LANGHEAD				2. DATE AND HOUR OF DEATH AUGUST 31, 1972 10:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 615 WINANS WAY				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 615 WINANS WAY 21229			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/18	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Central Off Repairman		10B. KIND OF BUSINESS OR INDUSTRY C & P Tel Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME late John				14. MOTHER'S MAIDEN NAME late Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 15-01-8054		17. INFORMANT ADDRESS Mrs. Dorothy Langhead 615 Winans Way 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/10/72 I CORONARY HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 1/15 1966 to 1/18 1971, that (I) (we) last saw the deceased alive on 1/18 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE Cliff Ratliff Jr. 23C. PHYSICIAN'S NAME (Type) Cliff Ratliff Jr. MD 23D. ADDRESS 5772 Westview Mall 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 9/4/72 24C. NAME OF CEMETERY or CREMATORY Crestlawn 24D. LOCATION (City, town, or county) (State) Howard County, Maryland 25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972 25B. NAME OF REGISTRAR Witzke, 1630 Edmondson Avenue 25C. FUNERAL DIRECTOR ADDRESS 21228							

ST. LOUIS, MO., 1891

RECEIVED

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08473		72 08473	
V-652 72 08473				CERTIFICATE OF DEATH		REG. NO. 72 08473	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
VERNACCHIO, FELIX				SEPTEMBER 3, 1972 7:10A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  40 ST. AGNES HOSPITAL				A. STATE		B. COUNTY	
				MARYLAND		CITY 21229	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				117 N. KOSSUTH STREET 2037			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	05 31 96	76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
COAL		COAL		ITALY		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				218017382		RECORDS OF ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				<p>1 - Generalized atherosclerosis</p> <p>2 - massive coronary sclerosis</p> <p>(A) IMMEDIATE CAUSE</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>3 - Left temporal lobe encephalomalacia</p> <p>(B) 4 - acute and chronic pulmonary infestation</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>5 - old Myocardial infarction</p> <p>(C)</p>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from AUGUST 29 1972 to SEPTEMBER 3 1972, that (X) (we) last saw the deceased alive on SEPTEMBER 3 1972 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (dXXX) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) FEREYDOUN DEHKHAREGHANI, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		9 3 72	
				23D. ADDRESS		ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Entombment		Sept. 6 '72		Lorraine Pk Mausoleum		Woodlawn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
SEP 6 1972		Sidney J. Witzke		Witzke 1630 Edmondson Ave Catonsville			

VERHEGHE, FELIX

SEPTEMBER 3, 1952

7:10

MARYLAND CITY

117 N. KOSCIUSKO STREET

ST. AGNES HOSPITAL

MALE CAUCASIAN

02 31 56

ITALY

COAL

COAL

U.S.A.

RECORDS OF ST. AGNES HOSPITAL  
CATON & WILKINS AVES. BALTO., MD. 21202

YES

AUGUST 22 1952

SEPTEMBER 3, 1952

XXX

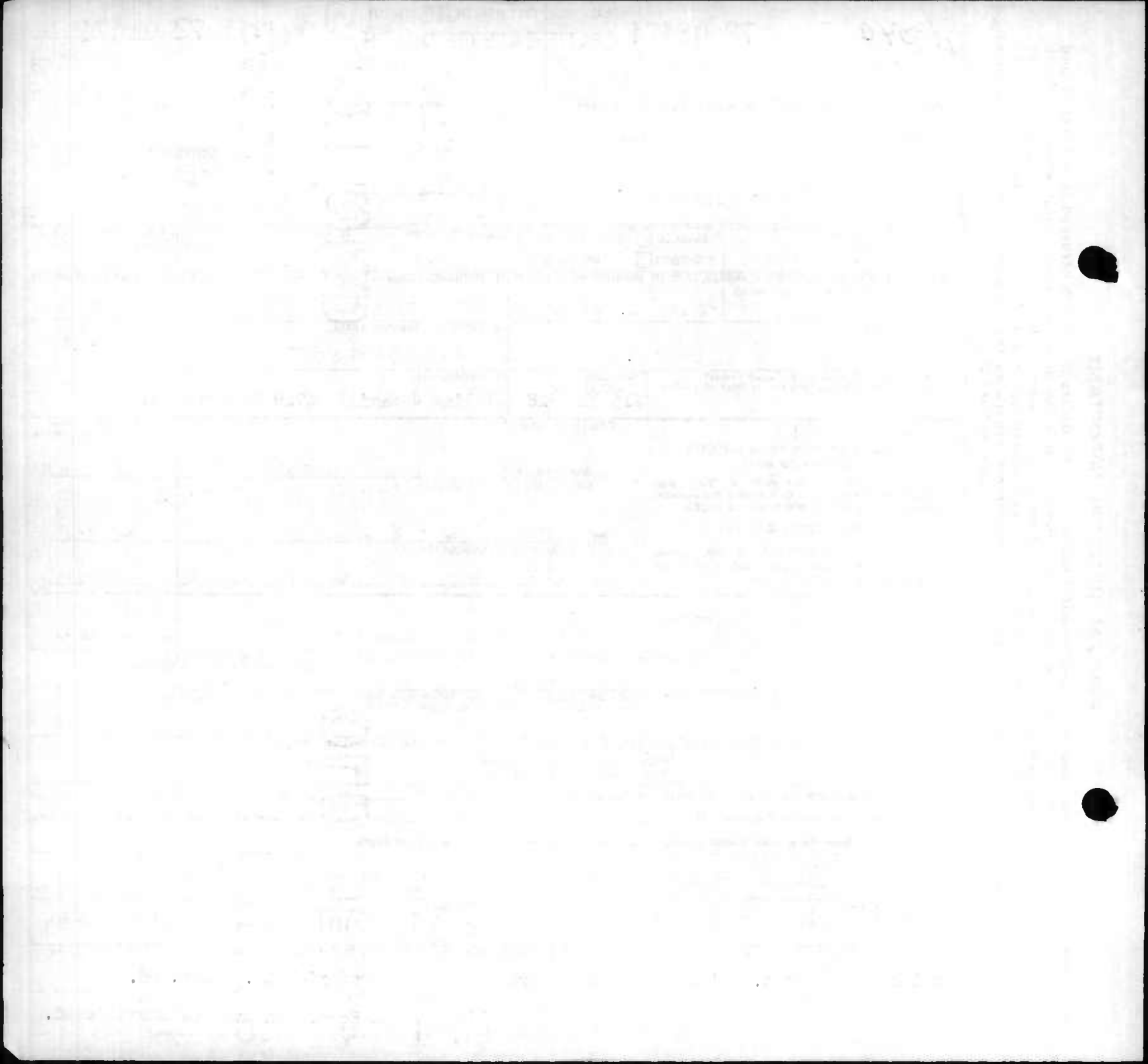
ST. AGNES HOSPITAL  
CATON & WILKINS AVES. BALTO., MD. 21202

FEREYDOON DEHKHARTEGHANI, M.D.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 08474</u>
72 08474 CERTIFICATE OF DEATH				STATE OF MARYLAND-DEPT
BIRTH NO. <u>A-540</u>		1. NAME OF DECEASED (Type or Print) <u>HAMILL, Helen M.</u>		
2. DATE AND HOUR OF DEATH <u>9/1/72</u> <u>8:15 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALT.</u>		C. CITY OR TOWN <u>BALT.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>4729 DARTFORD AVE BALT. MD 21229</u>		5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>7/11/11</u>		9. AGE (In years last birthday) <u>61</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MERCANTILE SAFE DEPOSIT &amp; TRUST</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CONRAD SCHUMAN</u>		
14. MOTHER'S MAIDEN NAME <u>MARGARET HILGARTNER</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>215 01 1928</u>		17. INFORMANT <u>William J Hamill</u>		
ADDRESS <u>4729 Dartford Ave</u>		18. <u>47091</u> CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Acute myocardial infarction, post wall of left ventricle</u> <u>24-48 hrs.</u>		
(B) <u>Coronary arteriosclerosis</u> <u>years</u>		(C) <u>Arteriosclerotic Heart Disease</u> <u>years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Generalized arteriosclerosis</u> <u>years</u>		
19A. DATE OF OPERATION <u>8-15-72</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PERMANENT ATHEROSCLEROSIS</u>	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>                    </u>	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>                    </u>		
22. I certify that (1) (this hospital) attended the deceased from <u>8-14-72</u> 19 <u>72</u> to <u>9-1-72</u> 19 <u>72</u> and that (1) (we) last saw the deceased alive on <u>at dead 9/1</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Sam Chen MD</u>		23B. DATE SIGNED <u>9-1-72</u>		23C. PHYSICIAN'S NAME (Type) <u>ARN C-KEEL MD</u>
23D. ADDRESS <u>2025 W. FAYETTE ST BALTO #23</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>Sept. 5 '72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Rd. Balto. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1972</u>		25B. NAME OF REGISTRAR <u>                    </u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave Catonsville Md.</u>





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08475		72 08475	
CERTIFICATE OF DEATH				REG. NO.		STATE OF MARYLAND - DEPT.	
BIRTH NO. L-200				1. NAME OF DECEASED (Type or Print) Frances Lewis		2. DATE AND HOUR OF DEATH 9/2/72 9:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 1512	
90 Jewish Convalescent Home				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2911 Rockrose Av. (21215)			
5. SEX F	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/19	9. AGE (In years last birthday) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Corprew				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-22-3902		17. INFORMANT William Lewis	
				ADDRESS 2516 Edgewood Ave			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 week	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				Uremia			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:		Unknown	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Nephrosclerosis			
II				(C) Cardio-megaly		Unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Cerebral thrombosis		7/12/72	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8/24/72 to 9/2/72, that (I) (we) last saw the deceased alive on 9/2/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Stewart, M.D.				23B. DATE SIGNED 9/2/72			
23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D.				23D. ADDRESS 2300 Garrison Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-7-72		24C. NAME OF CEMETERY or CREMATORY Arbutus Memory		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS 1701 - Laurens St	
				Dyett F. H			



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Printed at the Press of the  
Government of India, Delhi

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08476	
R-320 72 08476				STATE OF MARYLAND-DEPT	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Reddick Frank</b>			2. DATE AND HOUR OF DEATH <b>Aug. 31, 1972, 4:25 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hosp.</b>			A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>Baltimore, Md. 21215</b>			C. CITY OR TOWN <b>Bal.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>M</b> 6. RACE <b>N</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			E. STREET AND NUMBER <b>1040 N. Sturges St.</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			8. DATE OF BIRTH <b>3-7-22</b>		
10B. KIND OF BUSINESS OR INDUSTRY			9. AGE (In years last birthday) <b>50</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13. FATHER'S NAME <b>Frank Reddick</b>			14. MOTHER'S MAIDEN NAME <b>Ellen Reddick</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO. <b>212-14-1465</b>		
17. INFORMANT <b>Mrs. Grace Franklin (SISTER)</b>			ADDRESS <b>1405 Freemont Ave</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral hemorrhage, Pontine</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive cardiovascular disease</b>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia, bilateral</b>		
			(C) <b></b>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>8/31/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8/29</b> 19 <b>72</b> to <b>8/31</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>8/31</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>V. Chitraplee</b>				23B. DATE SIGNED <b>8/31/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>V. Chitraplee</b>				23D. ADDRESS <b>Provident Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-5-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		24E. NAME OF REGISTRAR <b>Arthur H. H. H.</b>		24F. FUNERAL DIRECTOR <b>Arthur H. H. H.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Arthur H. H. H.</b>		25C. FUNERAL DIRECTOR <b>Arthur H. H. H.</b>	
25D. ADDRESS <b>1701-1705 St.</b>					

Boyle  
Ellen Redlick

Frank Redlick

Received 9-2-18 the balance due the above named  
Helen Redlick to the amount of \$100.00

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 08477	
72 08477				72 08477	
BIRTH NO.				STATE OF MARYLAND - DISTRICT	
1. NAME OF DECEASED (Type or Print) JOHNSON, PRISCILLA			2. DATE AND HOUR OF DEATH 8/31/72 11-45 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERN HOSP OF Md. 46			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO CITY 1506 C. CITY OR TOWN BALTO, Md. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3035 WALKBROOK AVE		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/04	9. AGE (in years last birthday) 67	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Lancaster Co VA			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Monroe Grimes			14. MOTHER'S MAIDEN NAME Sina Grimes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO. 215-12-3428		
17. INFORMANT Louise Johnson			ADDRESS 3308 Oakfield Ave		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE pulmonary embolism. DUE TO, OR AS A CONSEQUENCE OF: (B) cerebrovascular accident. DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OIO INJURY OCCURRED (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/24/72 19 to 8/31/72 1972 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Sandou			23B. DATE SIGNED 8/31/72		
23C. PHYSICIAN'S NAME (Type) E. SANDOU, M.D.			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 9-6-72		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem, Balt, Md	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS		25E. ADDRESS			

House Gutter

Water (1/2 lb  
Sint Gutter

11/11

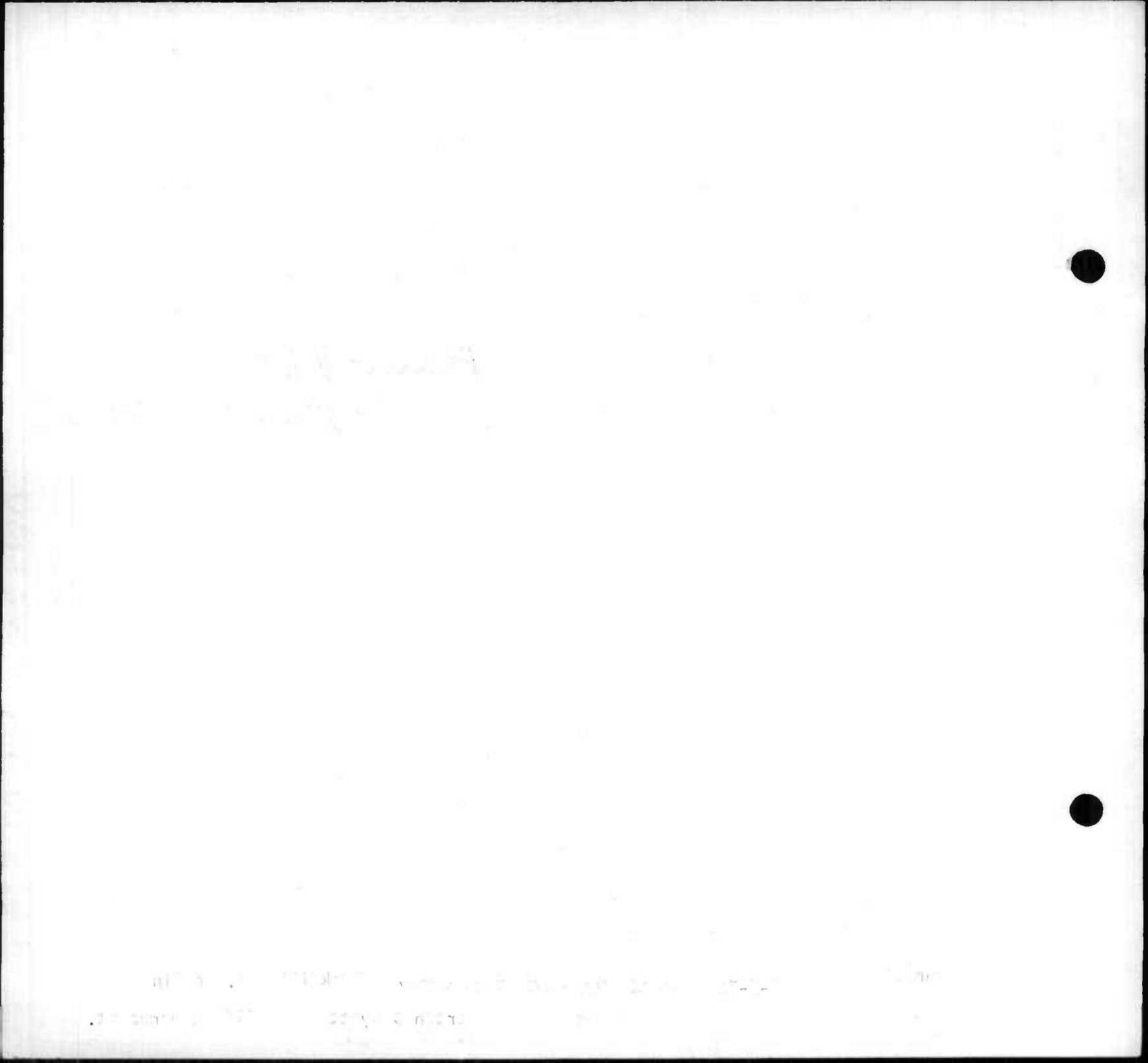
21-0-00 House Gutter

21-0-00 House Gutter  
11/11

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				72 08478		REG. NO. 72 08478	
BIRTH NO.				STATE OF MARYLAND - DULCH			
1. NAME OF DECEASED (Type or Print) <u>HARRISON, BETTY</u>				2. DATE AND HOUR OF DEATH <u>8/31/72</u> <u>16</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1607</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. HOSPITAL</u> <u>38</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12/20/37</u>		9. AGE (In years last birthday) <u>34</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>	
13. FATHER'S NAME <u>WILLIAM HARRISON</u>				14. MOTHER'S MAIDEN NAME <u>Florence White</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>(PATIENT) Macie Barber</u>	
18. <u>19901</u> CAUSE OF DEATH				ADDRESS <u>Brighton 2823</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Metastatic adenocarcinoma from unknown primary</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>00</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> 19 <u>72</u> to <u>8/31</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>8/30</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Philip J. Schrieder, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>8/31/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>PHILIP J. SCHRIEDER, M.D.</u>				23D. ADDRESS <u>UNIV. HOSPITAL, BALT., MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>9-5-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>ROCKHILL BAPTIST CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>Rockhill S. Carolina</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>SEP 6 1972</u>		25B. NAME OF REGISTRAR <u>Andrew H. ...</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett</u>		ADDRESS <u>1701 Laurens St.</u>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08479</b>	
<b>S-363</b>		<b>72 08479 CERTIFICATE OF DEATH</b>	
BIRTH NO. <b>72 08479</b>		STATE OF <b>MARYLAND-DHME</b>	
1. NAME OF DECEASED (Type or Print) <b>L. GEORGIA STRADER</b>		2. DATE AND HOUR OF DEATH <b>9/2/72 10:45 A</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>704</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>706 N. BROADWAY</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>06-16-16</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Counter Girl</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pharmacy</b>	9. AGE (in years last birthday) <b>56</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Smithburg, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alva G. Gabbert</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE COCHRANE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>229-36-4208</b>	
17. INFORMANT <b>Billy B. Strader</b>		ADDRESS <b>706 N. Broadway</b>	
18. <b>43191</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <i>Intracerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> 19 <u>72</u> to <u>Aug 2</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Aug 2</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Stephen H. Bennett</i>		23B. DATE SIGNED <b>9/2/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>STEPHEN H. BENNETT</b>		23D. ADDRESS <b>JOHNS HOPKINS HOSP.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-6-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Freeman</b>		24D. LOCATION (City, town, or county) (State) <b>West Union, Doddridge Co, W. Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <i>Lilly &amp; Zeiler Inc.</i>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901-07 Eastern Ave.</b>	

371

6021-32-000

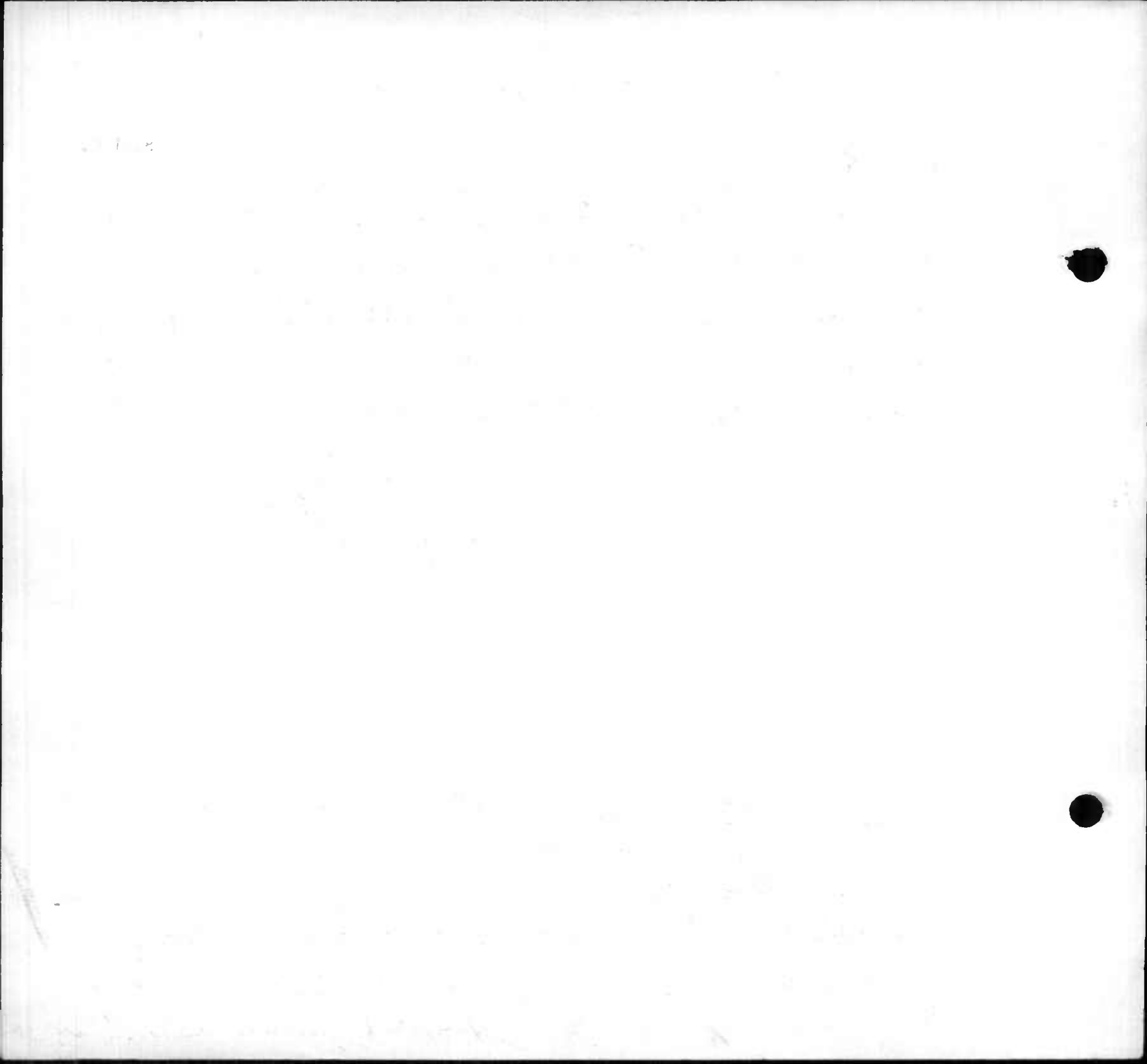
Seitliche West-Wand

82 81-82

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530		72 08480		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08480	
BIRTH NO.				STATE OF MARYLAND - DEPT. OF HEALTH			
1. NAME OF DECEASED (Type or Print) William F. Schmidt				2. DATE AND HOUR OF DEATH Sept 3, 1972 9:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2610			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 302 S. CLINTON ST.				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 302 S. CLINTON ST.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 4, 1896	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping clerk				10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Balto, Md	
12. CITIZEN OF WHAT COUNTRY U.S.A.				13. FATHER'S NAME Adolph			
14. MOTHER'S MAIDEN NAME MARGARET HAZEL BACH				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWI Army			
16. SOCIAL SECURITY NO. 216-10-0865				17. INFORMANT BARBARA M. Schmidt ADDRESS SAME			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE Arteriosclerotic CV			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF: Disease			
ANTECEDENT CAUSES				(B) Generalized Arteriosclerosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/18 1960 to 9/2 1972 that (I) last saw the deceased alive on 9/2 1972 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE Henry J. Houska				23B. DATE SIGNED 9/5/72		23C. PHYSICIAN'S NAME (Type) DR. Henry J. Houska	
23D. ADDRESS 333 S. EAST AVE.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Sept 6, 1972		24C. NAME OF CEMETERY or CREMATORY Sacred Heart		24D. LOCATION (City, town, or county) Balto (State) Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS 263 CONKLING ST	



## 72 08481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08481

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PAUL BROWN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour September 2, 1972 8:31 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour September 2, 1972 8:30 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1002			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. CITY OR TOWN Baltimore
10. AGE (In years lost birthday) 40		11. DATE OF BIRTH Sept 26, 1931	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Hezekiah Brown	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Grace Jones	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Shirley Brown		ADDRESS 906 Wilmot Ct	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidewalk	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1200 E. Madison Street 1002		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 9-2-72 7:58 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type): Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: September 3, 1972			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 9/7/72	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A. A. County, Md	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR Maryland Registrar	
25C. FUNERAL DIRECTOR Joseph P. Locks		ADDRESS 13042 Central Ave	

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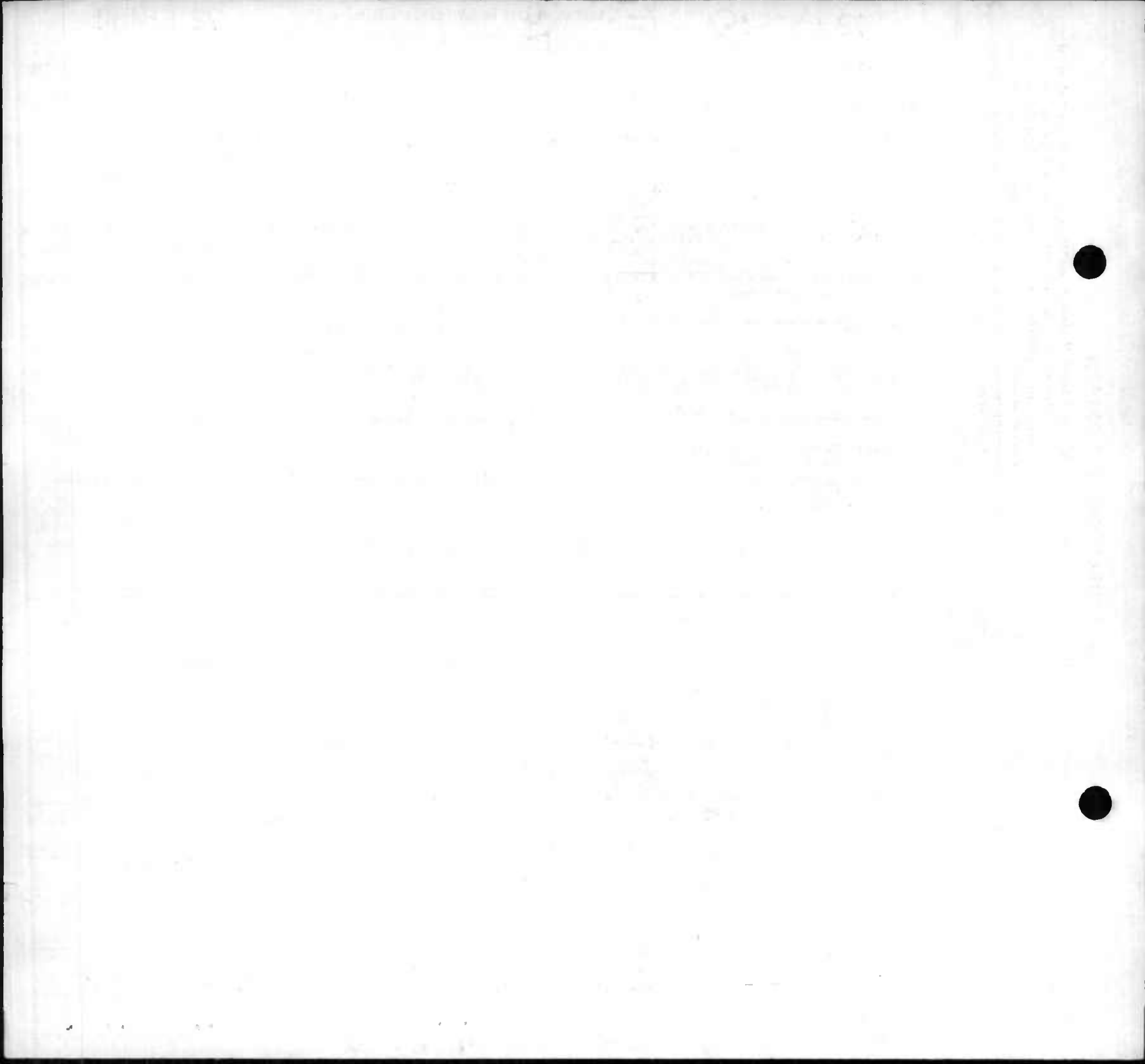
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CHICAGO, ILL. 60607

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 08482	
BIRTH NO. 72 08482				1. NAME OF DECEASED (Type or Print) <b>CHARLES RIFE HILGARTNER</b>		2. DATE AND HOUR OF DEATH <b>Sept 6 1972</b> <b>1 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>802 St GEORGES Rd BALTO, MD</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALTO</b> B. COUNTY <b>City MD</b>		C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 13, 1915</b> 9. AGE (in years last birthday) <b>57</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>City of BALTO</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO</b>	
13. FATHER'S NAME <b>CHARLES E. HILGARTNER</b>				14. MOTHER'S MAIDEN NAME <b>CITELIA RIFE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWII KOREA</b>				16. SOCIAL SECURITY NO. <b>213-18-6121</b>		17. INFORMANT <b>Mrs. Chas R. Hilgartner</b> ADDRESS <b>802 St Georges Rd BALTO MD</b>	
18. <b>145-9 I</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma of rectum</b>		<b>10 months</b>	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Metastasis - neck</b>			
(C) _____							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>21 March 72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma left buccal area</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>August 1</b> 19 <b>72</b> to <b>Present</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Sept 5</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William A. Dodd</b> DEGREE				23B. DATE SIGNED <b>Sept 5 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>William A. Dodd MD</b>	
23D. ADDRESS <b>Sea Island Georgia 31561</b>				24. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9-7-72</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Edwin H. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co., Balto., Md.</b>			

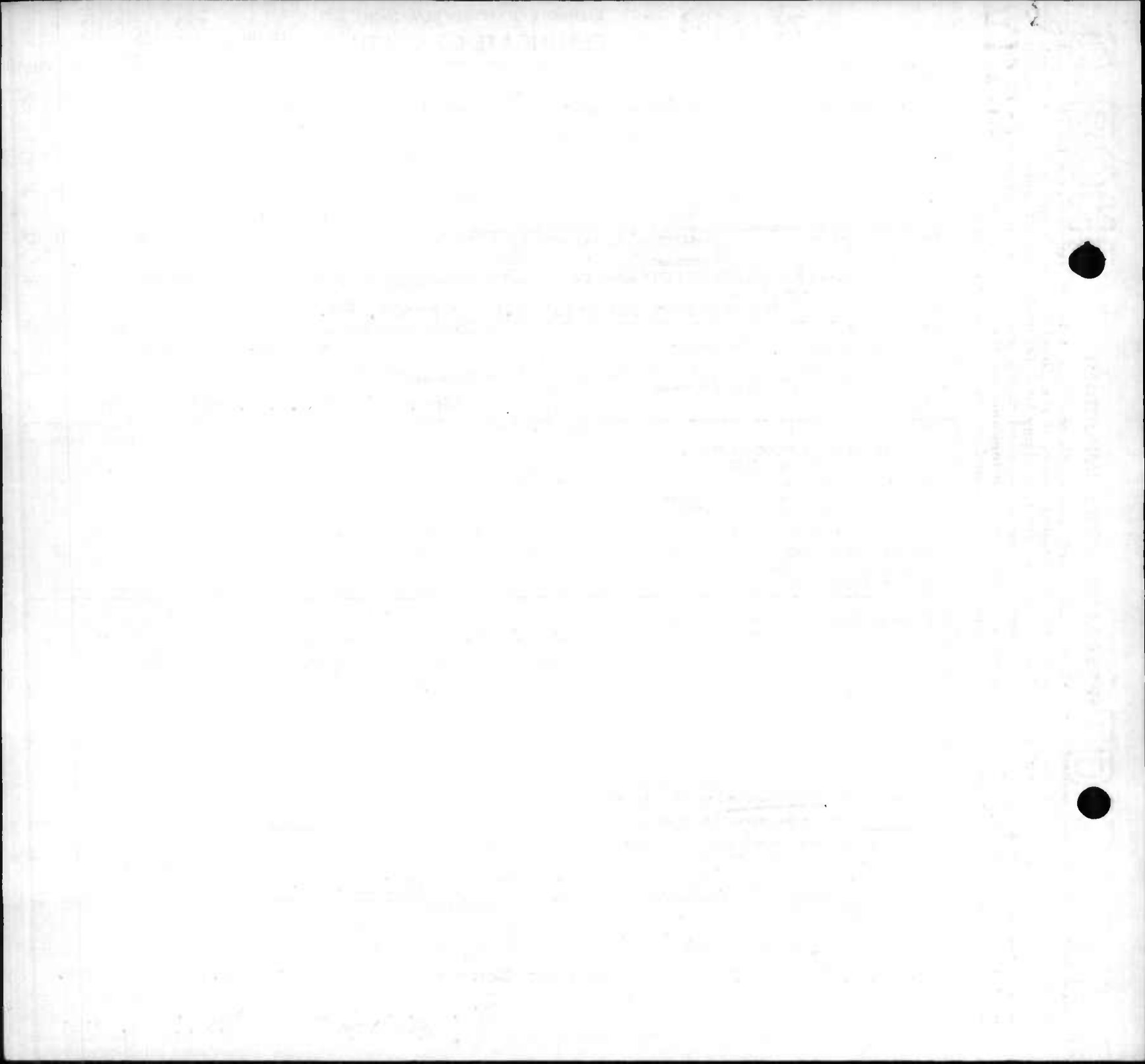




FUNERAL DIRECTOR: IMPORTANT

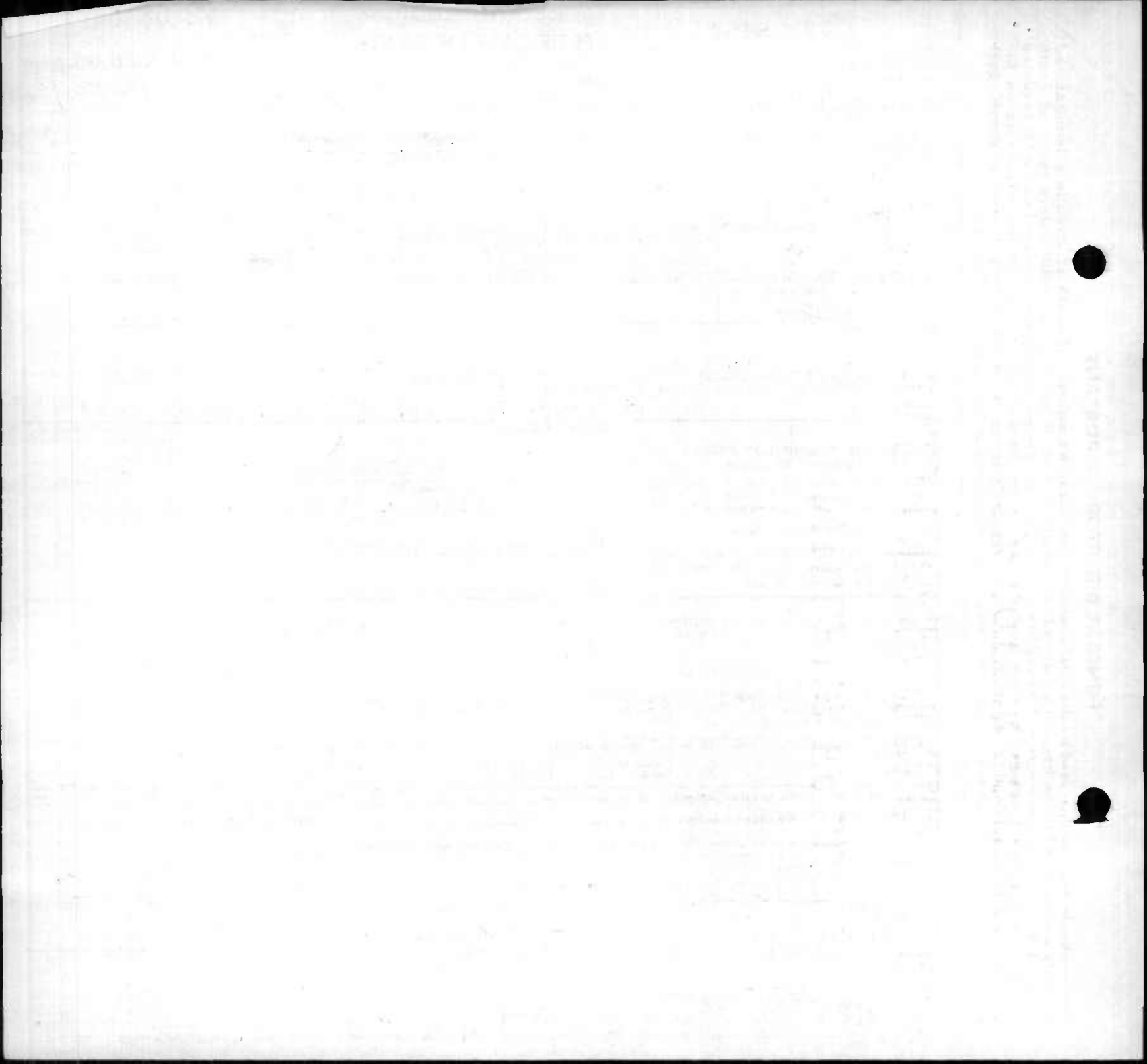
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 08483</b>	
BIRTH NO. <b>72 08483</b>		STATE OF MARYLAND - DHMH	
1. NAME OF DECEASED (Type or Print) <b>Robert J. Prudhoe, Sr.</b>		2. DATE AND HOUR OF DEATH <b>9/1/72</b> <b>1:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>8 Md. General Hospital</b>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2410 Lake Ave. - 21213</b>			
5. SEX <b>M</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/20/98</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd. Machinist Western Electric Co.</b>		9. AGE (In years last birthday) <b>73</b>	11. BIRTHPLACE (State or foreign country) <b>Orange, Pa.</b>
13. FATHER'S NAME <b>James L. Prudhoe</b>		12. CITIZEN OF WHAT COUNTRY <b>USA.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>189-01-2592</b>	17. INFORMANT <b>Mrs. Robert J. Prudhoe</b>
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arterioscler. C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Pulmonary occlusion</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b> <b>Ventricular tachycardia, fibrillation</b>			
19A. DATE OF OPERATION <b>2/1</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/1/72</b> 19 to <b>9/1/72</b> 19 that (I) (we) last saw the deceased alive on <b>9/1/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>James H. Biddison, MD.</b>		23B. DATE SIGNED <b>9/1/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>James H. Biddison MD.</b>		23D. ADDRESS <b>Md. General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem-Burial</b>	24B. DATE <b>9-5-72</b>	24C. NAME of CEMETERY or CREMATORY <b>Bloomingdale Cemetery</b>	24D. LOCATION (City, town or county) (State) <b>Luzerne Co., Pa.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>	25B. NAME OF REGISTRAR <b>Audrey Johnston</b>	25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08484		REG. NO.	
BIRTH NO.				72 08484			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANNIE C. ASHER				9. 3. 72 11-50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Maryland General Hospital				Maryland			
C. CITY OR TOWN				D. INSIDE CITY LIMITS			
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				4625 Harcourt Rd 2741			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birth day)	If Under 1 Yr. Months: Days: Hours: Min.		
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	02-04-13	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker				VA.		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank Conley				Carrie Stott			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				220-48-1701		Mr. William E. Asher Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				2 yrs			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Adenocarcinoma			
				DUE TO, OR AS A CONSEQUENCE OF:			
				Rectum (metastatic)			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Bronchial Asthma			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
none						No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8. 15. 72 19 to 9. 3. 19 72 that (I) (we) last saw the deceased alive on 9. 3. 72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
AHSAN SAEED KHAN M.D.				9. 3. 72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
AHSAN SAEED KHAN M.D.				Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				9-6-72		Druid Ridge Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
SEP 6 1972				Sydney H. [Signature]		Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212	



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S-5 30

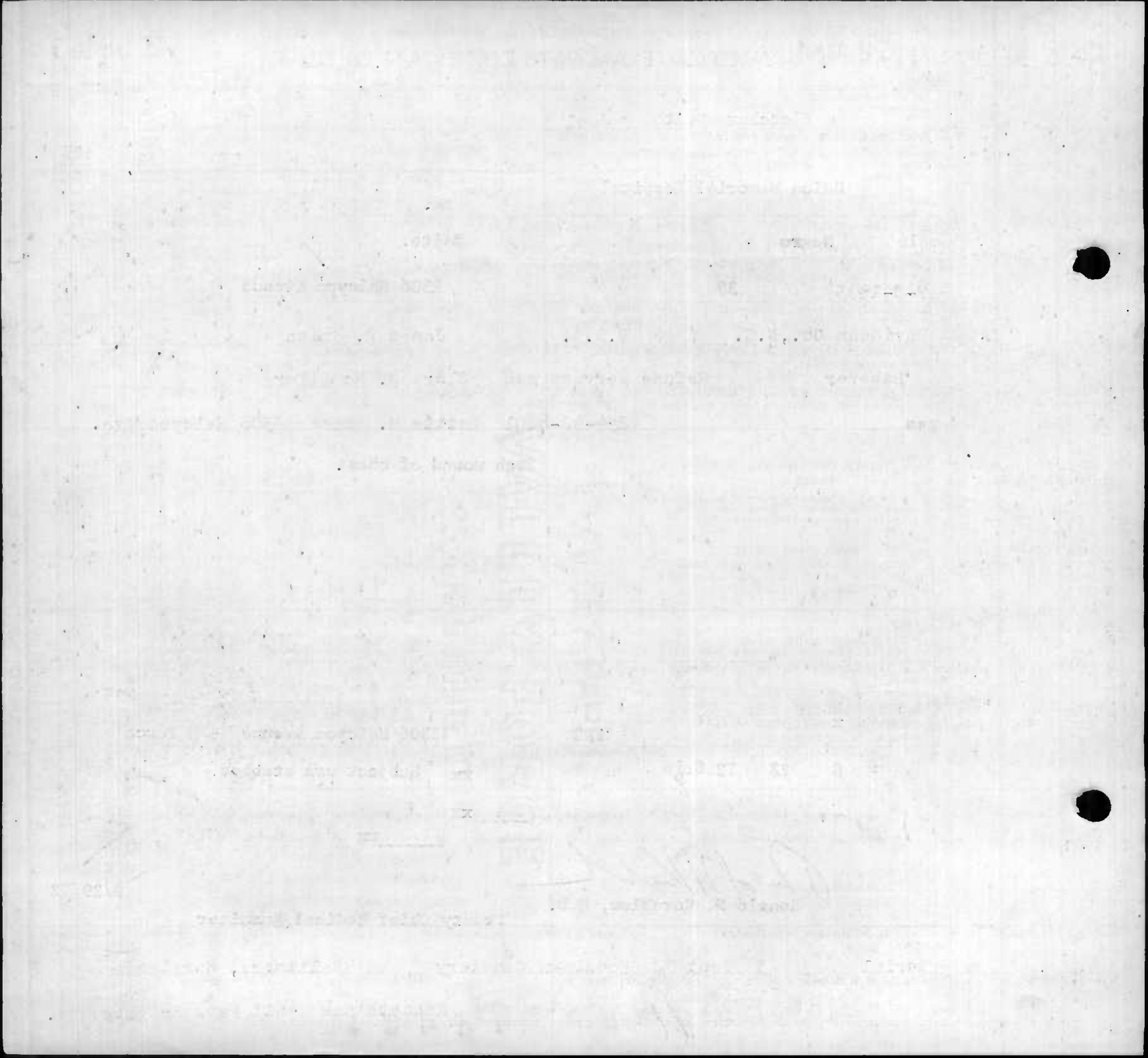
BALTIMORE CITY HEALTH DEPARTMENT

72 08485

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08485

BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Fletcher Smith Joel				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 8 28 72 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 8 28 72 10:25 p. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2733							
6. SEX male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7-3-1933				10. AGE (In years last birthday) 39		E. STREET AND NUMBER 2306 Halcyon Avenue	
11. BIRTHPLACE (State or foreign country) Davidson Co., N.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James P. Smith	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				14B. KIND OF BUSINESS OR INDUSTRY Refuse Service man		15. MOTHER'S MAIDEN NAME Clara B. McMiller	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes				17. SOCIAL SECURITY NO. 254-42-8601		18. INFORMANT ADDRESS Hattie M. Smith 2306 Halcyon Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Stab wound of chest CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME			
22D. TIME OF INJURY (APPROX.) 8 28 72 6:16 p. m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2306 Halcyon Avenue - Porch				22F. HOW DID INJURY OCCUR? Subject was stabbed. 2733			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED 8/29/72							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3 Sept 72		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR Sidney H. Boston		25C. FUNERAL DIRECTOR Kenneth Law		ADDRESS 4611 Park Heights Ave.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		72 08486		BALTIMORE CITY HEALTH DEPARTMENT		72 08486	
CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mohr, George</i>		2. DATE AND HOUR OF DEATH <i>8-27-72 5:30 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2717</i>		STATE OF MARYLAND, DISTRICT			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Mt. Sinai Nursing Home</i> <i>4413 Park Heights Ave 21215</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M.</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-27-05</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>67 yrs</i>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>465-07-9868</i>		17. INFORMANT <i>Sally Mohr, 4831 Park Heights Ave.</i>		ADDRESS	
18. <i>4124 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic C-V Disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cerebral Accident</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Accident</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>5</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>March 17 1972</i> to <i>Aug 27 1972</i> that (I) (we) last saw the deceased alive on <i>Aug 26 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <i>not</i> view the body after death.							
23A. SIGNATURE <i>Louis T. Lavay M.D.</i>		23B. DATE SIGNED <i>Aug 28-1972</i>		23C. PHYSICIAN'S NAME (Type) <i>LOUIS T. LAVAY M.D.</i>		23D. ADDRESS <i>3502 W. Rogers Baltimore Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>8/30/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Anatomy Borad</i>		24D. LOCATION (City, town, or county) (State) <i>University Med. School, Bal, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>SEP 6 1972</i>		25B. NAME OF REGISTRAR <i>Ludwig H. Heston</i>		25C. FUNERAL DIRECTOR <i>Kenneth Lay</i>		ADDRESS <i>4611 Park Heights Ave.</i>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 08487

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>COZIE MAE HUNTER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> August 30, 1972 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2203 E. Jefferson Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour August 30, 1972 12:10 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY <b>603</b>	
10. DATE OF BIRTH		11. AGE (in years last birthday) 49	
12. BIRTHPLACE (State or foreign country)		13. CITIZEN OF WHAT COUNTRY?	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		15. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Frankie Hunter</b>		ADDRESS <b>2203 E. Jefferson Street</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b>		CAUSE OF DEATH <b>Hypertensive cardiovascular disease</b>	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME (Month) (Day) (Year) (Hour) (Approx.)		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22H. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Marvin S. Platt</b> EXAMINER'S NAME (Type)		DATE SIGNED <b>August 31, 1972</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>9-2-72</b>	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Raleigh, North Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Sidney Houston</b>	
25C. FUNERAL DIRECTOR <b>Charles H. Greenwood</b>		ADDRESS <b>1024 N. E. 10th St</b>	

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50 53

UNITED STATES OF AMERICA

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H-340

72 08488

BALTIMORE CITY HEALTH DEPARTMENT

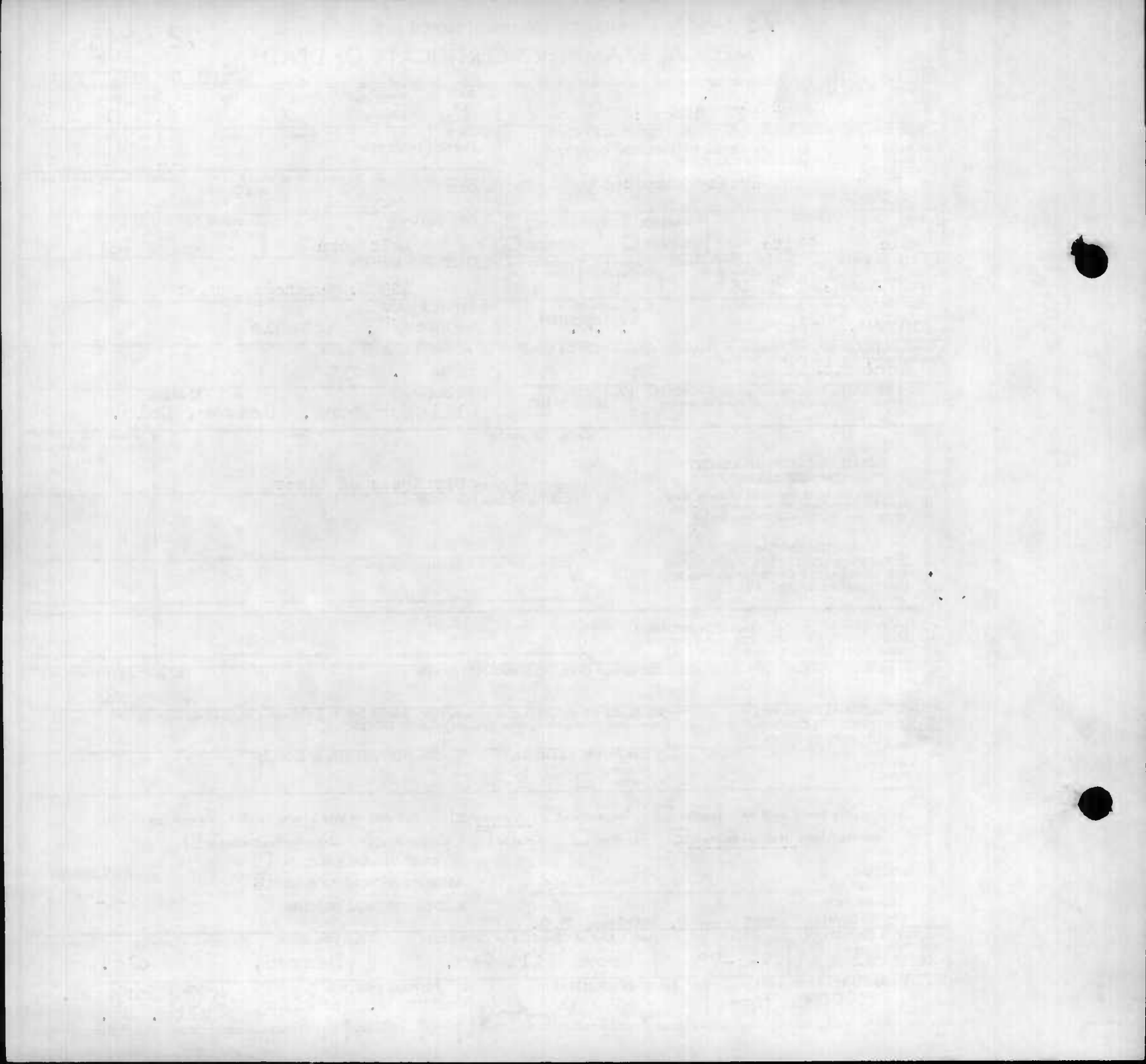
72 08488

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.  
STATE OF MARYLAND-DEMH

1. NAME OF DECEASED (Type or Print) H. Tracy Heatwole		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 9 1 72 10:10 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year 9 1 72 10:10 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 401	
9. DATE OF BIRTH Apr. 12, 1926		10. AGE (in years last birthday) 46	
11. BIRTHPLACE (State or foreign country) Denver, Colorado		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Tracy C. Heatwole		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant	
15. MOTHER'S MAIDEN NAME Edna M. Hoyt		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Ollinger Mort. Denver, Colo.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) William P. Mulloy, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-1-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 9-4-72	
24C. NAME of CEMETERY or CREMATORY Crown Hill Cem.		24D. LOCATION (City, town, or county) (State) Denver, Colo.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR Sidney Johnston	
25C. FUNERAL DIRECTOR Henry W. Jenkins		ADDRESS 4905 York Rd. Balto. Md.	

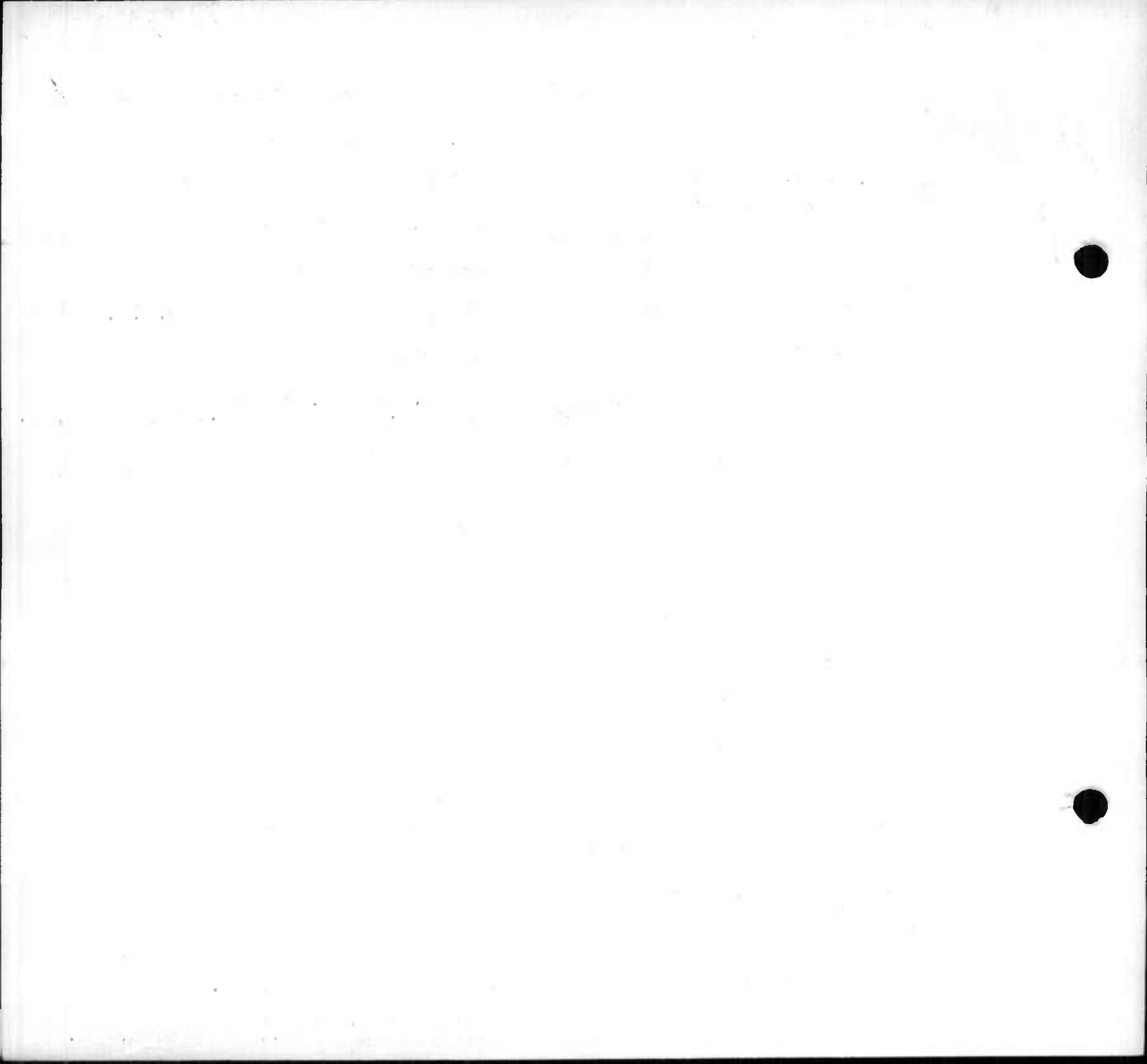


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08489	
A-352 D35072 68489				REG. NO.	
BIRTH NO.				STATE OF MARYLAND-DMH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
PHILIP ADAMS (D'ADAMO)			August 30, 1972 2:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
114 N. Curley Street Baltimore, Maryland			Md. Baltimore 601		
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male			White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
Laborer			Utility		3-17-87
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)
Guiseppe D'Adamo			Concetta		85
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)
No			212-05-5206A		Italy
17. INFORMANT			12. CITIZEN OF WHAT COUNTRY?		
Mrs. Anna A. Jondo			U.S.A.		
ADDRESS			401 N. Highland Ave., Baltimore, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			Pseudo Bulbar PARALYSIS		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			Cerebral Arteriosclerosis		
			DUE TO, OR AS A CONSEQUENCE OF:		
II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			2 months		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		11 months
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
(APPROX.)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Aug 21 1972 to Aug 27 1972 that (I) (we) last saw the deceased alive on August 27 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Anthony A. Lewandowski M.D.			09-01-72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
ANTHONY A. LEWANDOWSKI M.D.			11 E CHASE ST BALTIMORE Md. 21202		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial		9-2-72	Holy Redeemer Cemetery		Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
SEP 6 1972		Nicholas E. Matthews		ADDRESS	
				3021 Eastern Ave., Baltimore, Md.	



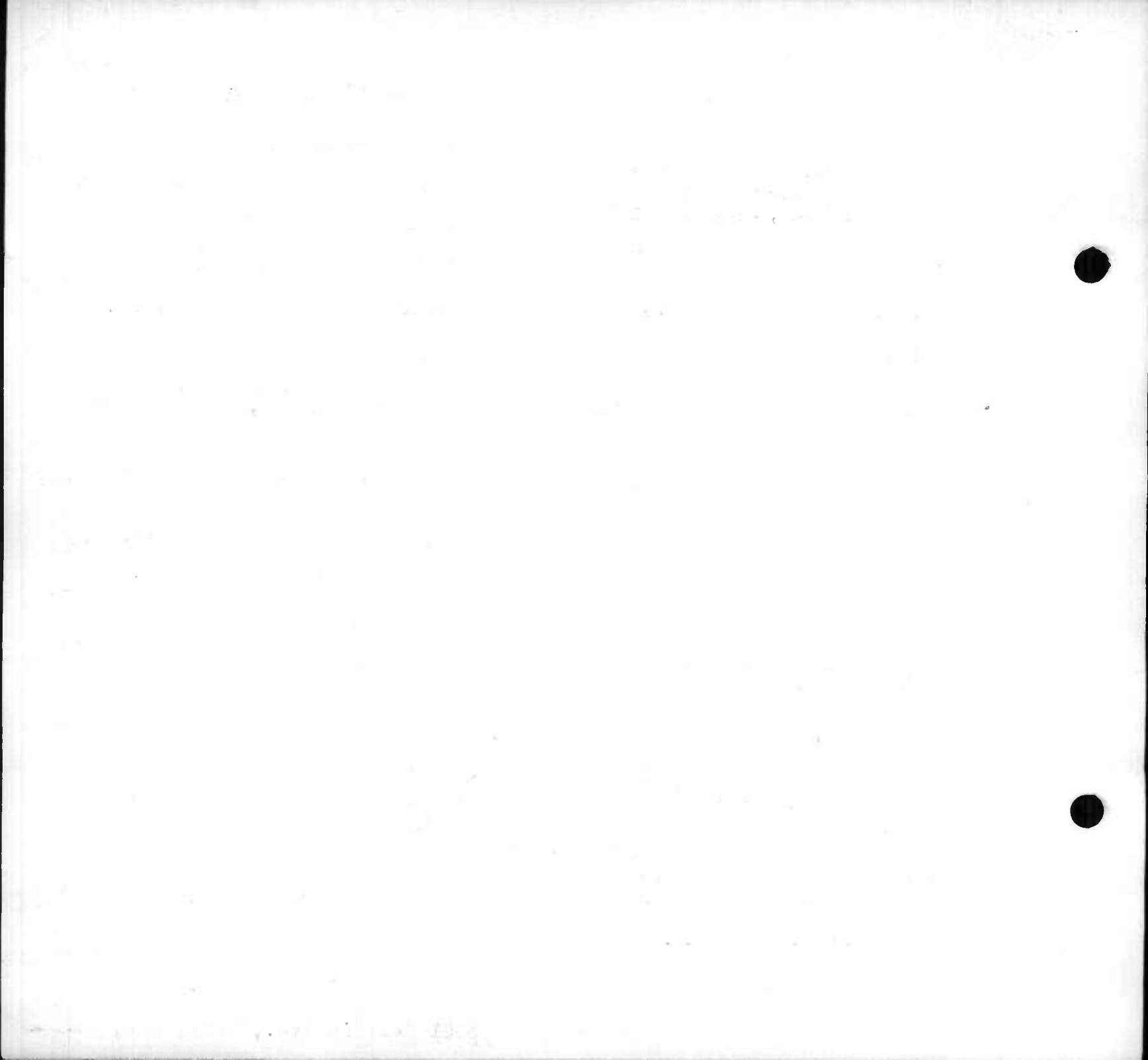


61-72-05 pm

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 08490		REG. NO.	
CERTIFICATE OF DEATH							
BIRTH NO.		72 08490		STATE OF MARYLAND-DEHMT			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Dan Rosus				8-31-72 12:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Baltimore City Hospitals				Maryland Baltimore			
4940 Eastern Avenue				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
31 Baltimore, Maryland 21224				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				1102 Dundalk Avenue 21224			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?		
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/10/94	77	U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Steel		Greece		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Stelios Rosus				Athanasia			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		236-03-4998		BCH Records Baltimore, Maryland 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		7 days	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:		10 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Small bowel obstruction		10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Carcinoma of colon		2 mos.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
18-21-72		Small bowel obstruction		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 8-31-72 to Aug-31-1972 that (I) <del>last</del> saw the deceased alive on Aug-31-1972 and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>last</del> (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Frederick W. Walker, M.D.				8-31-72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
Frederick W. Walker M.D.		Baltimore City Hospitals		4940 Eastern Avenue Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		9-4-72		Greek Orthodox Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 6 1972		Nicholas P. Matthews		3021 Eastern Ave., Baltimore, Md.			



S-530

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 08491

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HARRY MONROE SMITH SR		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour August 30, 1972 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour August 30, 1972 11:30 P.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY ANNE ARUNDEL	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Edgewater D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Nov 27 1928		10. AGE (In years last birthday) 43		E. STREET AND NUMBER Rte 2, Box 164 H 5200	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARTHUR SMITH	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		14B. KIND OF BUSINESS OR INDUSTRY PETROLEUM		15. MOTHER'S MAIDEN NAME LOTTIE MAY TURNER	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES 1946-1947		17. SOCIAL SECURITY NO. 577 42 2781		18. INFORMANT ADDRESS MARGUERITE L. SMITH # 543CE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rte 178 east of Crownsville, Md.	
22D. TIME OF INJURY (APPROX.) 8-30-72 10:20 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto-auto collision; car struck from behind causing subject to be thrown out	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Marvin S. Platt, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED August 31, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3 SEPT 1972		24C. NAME OF CEMETERY or CREMATORY CHRIST CHURCH CEM.	
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR Aldrey W. ...		25C. FUNERAL DIRECTOR JOHN M. TAYLOR, SON ANNAPOLIS MD	
24D. LOCATION (City, town, or county) (State) CHARTICO, ST MARYS CO MD.					

Barrie 22nd Regiment (Queen's) 2nd Battalion  
Light Infantry 2nd Battalion

Barrie 22nd Regiment (Queen's) 2nd Battalion  
Light Infantry 2nd Battalion

Barrie 22nd Regiment (Queen's) 2nd Battalion  
Light Infantry 2nd Battalion

Barrie 22nd Regiment (Queen's) 2nd Battalion  
Light Infantry 2nd Battalion

Barrie 22nd Regiment (Queen's) 2nd Battalion  
Light Infantry 2nd Battalion

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08492

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) BETTY DUNN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year September 2, 1972		Hour 9:25 A. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year September 2, 1972		Hour 9:25 A. M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA				
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Pasadena
9. DATE OF BIRTH		10. AGE (In years last birthday) 16	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Ba ltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER Route 3, Box 115
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY School		13. FATHER'S NAME William T. Dunn, Sr.
15. MOTHER'S MAIDEN NAME Eilleem S. Gravel		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		
17. SOCIAL SECURITY NO. 212-70-3688		18. INFORMANT ADDRESS Father - same 5		
19. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bridge		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Hawkins Point Rd W. of Ordance Road
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 8-27-72 9:10 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver in auto-auto collision 5200
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> September 3, 1972 ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 Sept. 72	24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Co., Md.		24E. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.		
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 08493  
REG. NO.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT EUGENE MYERS

2. DATE OF DEATH Known ☒ Month Day Year Hour  
Estimated ☐ August 27, 1972 2:40 A. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
OR INSTITUTION

Johns Hopkins Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
August 27, 1972 2:40 A. M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

8-7-46

10. AGE (In years last birthday)

26

11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1632 E. Federal Street

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Myers

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mae Alston

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, next unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mae Coleman 1632 E. Federal St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of abdomen  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

1632 E. Federal Street

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

8-26-72 10:58 P. M.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

August 27, 1972

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

8-31-72

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State)

Westport, Md.

25A. DATE REC'D BY HEALTH DEPT.

SEP 6 1972

25B. NAME OF REGISTRAR

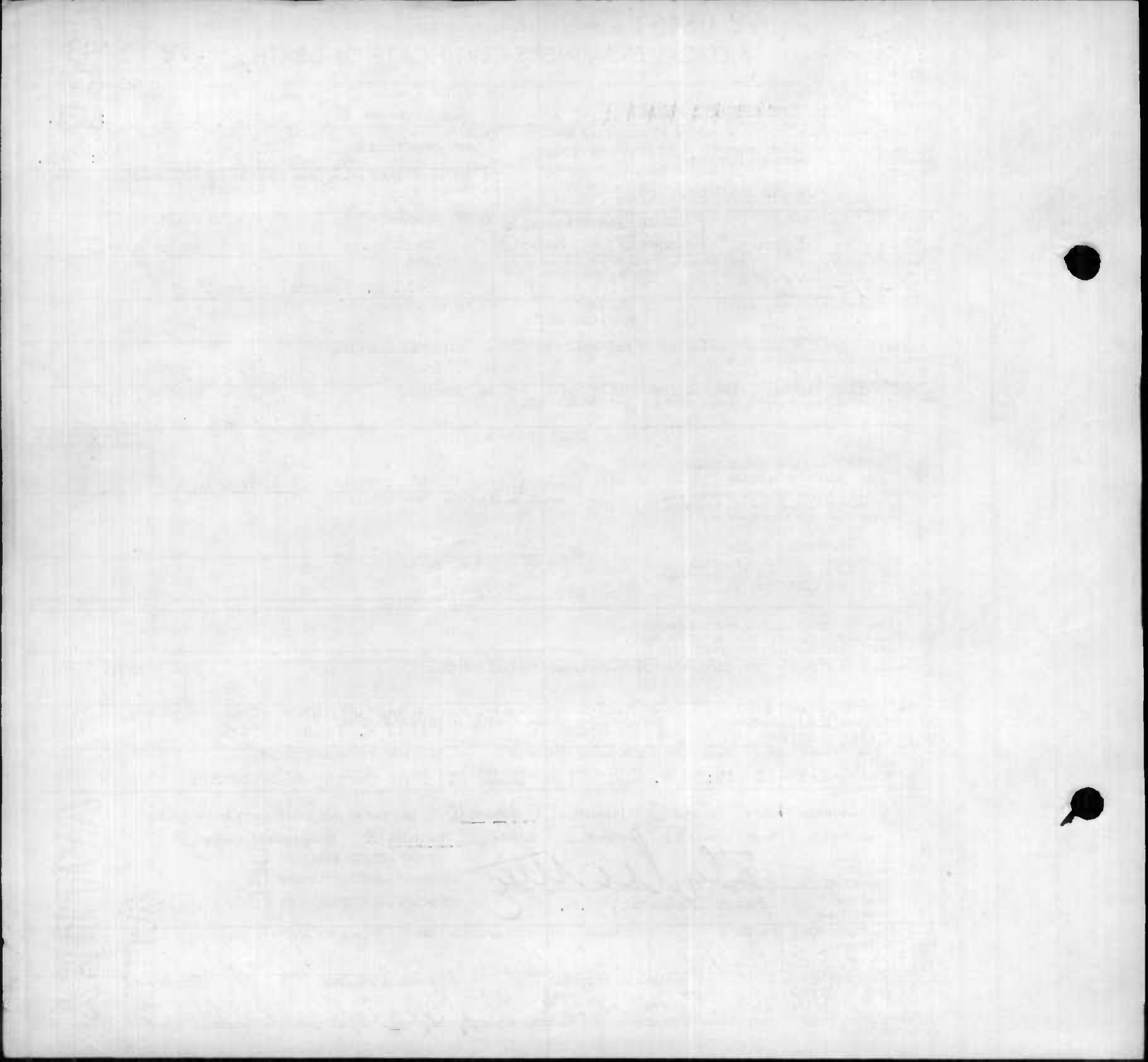
Lidney

25C. FUNERAL DIRECTOR

F. H. H. Federal Home

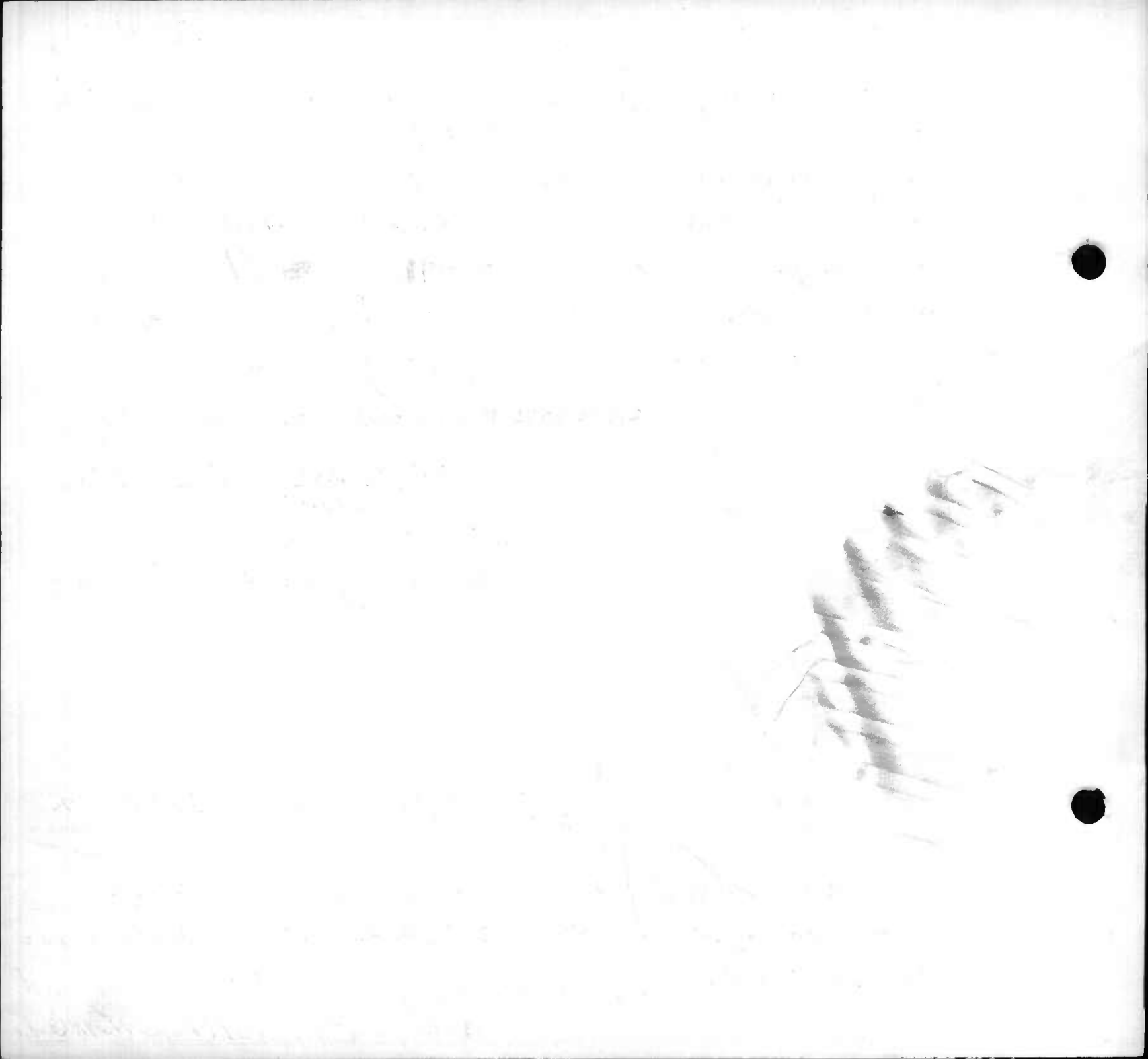
ADDRESS

1129 N. Carolina



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

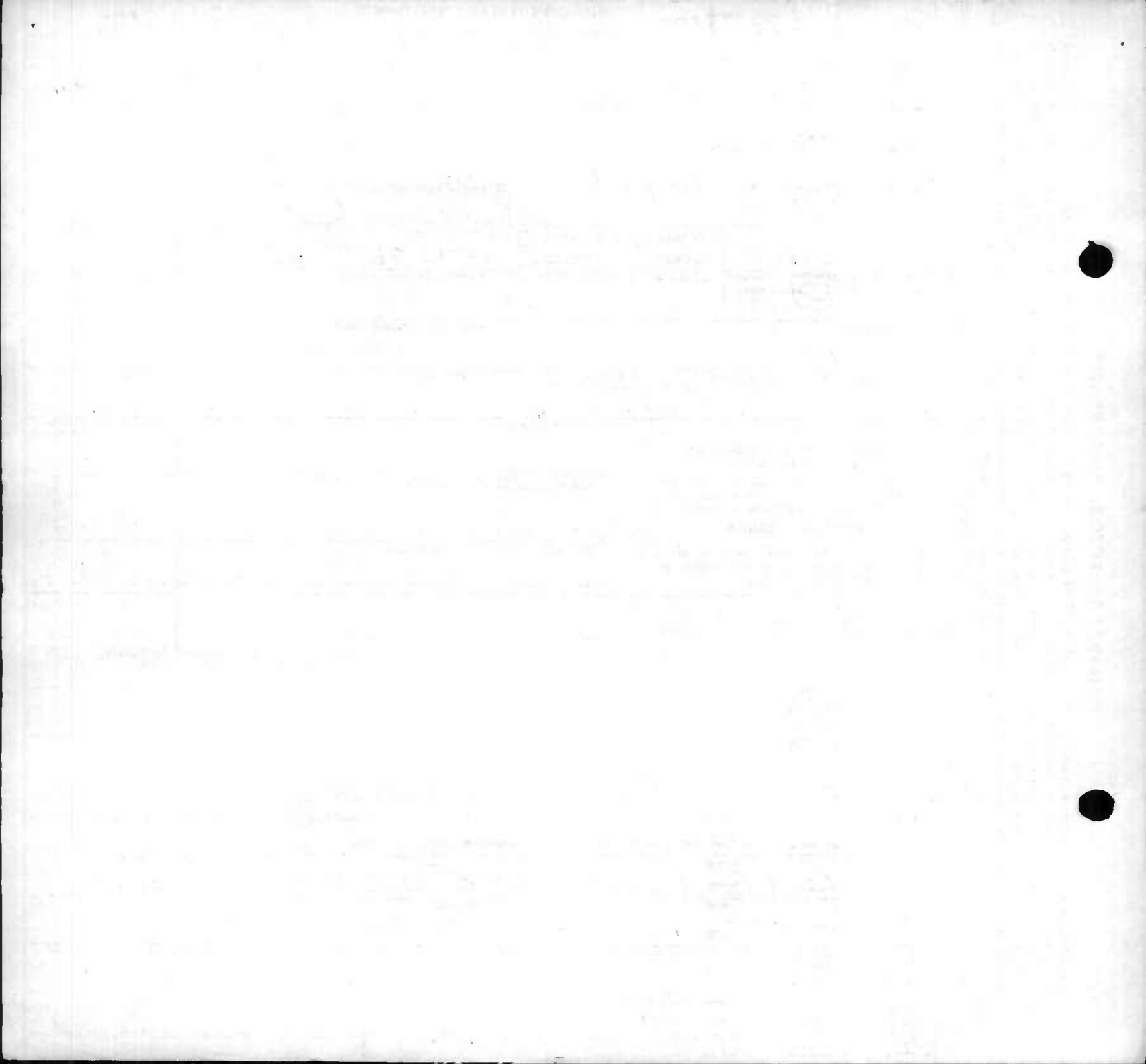
<p><b>M-340</b>      <b>72 08494</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>72 08494</b></p> <p style="font-size: 0.8em;">STATE OF MARYLAND—DHMH</p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>Florin Medley (Flora)</b></p>		<p>2. DATE AND HOUR OF DEATH <b>8-27-72 12:05 A.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bolton Hill Nursing &amp; Convalescent Center Lafayette &amp; John Sts. Baltimore, Maryland</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1602</b></p> <p>C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1306 W. Lanvale St.</b></p>	
<p>5. SEX <b>F</b></p>	<p>6. RACE <b>Negro</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>5-3-91</b></p>
<p>9. AGE (in years last birthday) <b>81</b></p>		<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>—</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>MD.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>unknown</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Mary Lee</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>217-56-8570</b></p>	<p>17. INFORMANT <b>Fannie Reed</b> ADDRESS <b>1306 W. Lanvale St.</b></p>
<p>18. CAUSE OF DEATH</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>(A) IMMEDIATE CAUSE <b>CA / Valvular rth</b> <b>1971</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF: <b>retastom</b></p> <p>(B) <b>arteriosclerotic heart disease</b> <b>years</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <b>arteriosclerotic generalized</b> <b>years</b></p> </div> </div>			
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <b>8/27</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>8/27 1972</b> to <b>8/27 1972</b> that (I) (we) last saw the deceased alive on <b>8/27 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>ALLAN H. MACHT MD</b></p>		<p>23B. DATE SIGNED <b>8/28/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MACHT MD</b></p>		<p>23D. ADDRESS <b>2 E READ ST. BALTIMORE MD 21202</b></p>	
<p>24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>9-1-72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>MT. Zion Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>St. Marys County Md.</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Ludwig</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Funeral Home</b></p>		<p>25D. ADDRESS <b>1129 N. Calver</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-600		72 08495		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 08495	
CERTIFICATE OF DEATH				STATE OF MARYLAND			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Emma Terry		8-25-72 5:28 PM		Johns Hopkins Hospital		M.D. 605	
5. SEX F		6. RACE B		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-13-06	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		—		Md.		U.S.A.	
13. FATHER'S NAME George Green				14. MOTHER'S MAIDEN NAME Laura Thomas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		212-30-7760		Elizabeth Hall		9137 Duncon St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>4124</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				<p>(A) IMMEDIATE CAUSE Cardiac arrest</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p>		0:00	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>				<p>(B) Myocardial infarction or digoxin toxicity</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p>		72:00	
<p>(C) Atherosclerotic cardiovascular disease</p> <p>several years</p>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 3: PM 8-25-72 19 to 5:28 PM 8-25-19 72 that (1) (we) last saw the deceased alive on 8-25-72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Gail G. Ahmed				8-25-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Gail Ahmed, M.D.				The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		8-30-72		Ft. Calvary Cem.		A. A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
SEP 6 1972		Andrew J. Wilson		Elizabeth Funeral Home		129 N. Caroline	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 08496		72 08496	
W-316		72 08496		72 08496	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ELIZABETH WAT FORD</b>		2. DATE AND HOUR OF DEATH <b>8-24-72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1547</b>		5. <b>A</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2306 LONGWOOD ST</b>		6. SEX <b>F</b>		7. RACE <b>N</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <b>4-25-16</b>		10. AGE (In years last birthday) <b>56</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautician</b>		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (State or foreign country) <b>Arlanese</b>	
14. FATHER'S NAME <b>unknown</b>		15. MOTHER'S MAIDEN NAME <b>Rose ?</b>		16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>213-12-3899</b>		19. INFORMANT <b>Center Watford-2306 Longwood St</b>	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIORESPIRATORY ARREST</b>		21. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>UREMIA</b>		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CVA / HYPERTENSION</b>		24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
26. DATE OF OPERATION		27. CONDITION FOR WHICH OPERATION WAS PERFORMED		28. AUTOPSY? (Yes or No) <b>NO</b>	
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
32. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		34. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-26-1916</b> to <b>8-24-1972</b> that (I) (we) last saw the deceased alive on <b>8-24-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William G. [Signature]</b>		23B. DATE SIGNED <b>8-24-72</b>		23C. PHYSICIAN'S NAME (Type) <b>RUBEN MARIQUEZ MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>8-30-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arlanese Mem Park</b>	
24D. LOCATION <b>Arlanese, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Disney [Signature]</b>	
25C. FUNERAL DIRECTOR <b>K. H. [Signature]</b>		25D. ADDRESS <b>Funeral Home-1129 A [Signature]</b>		25E. ADDRESS	



X

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.						BALTIMORE CITY HEALTH DEPARTMENT						REG. NO.											
72 08497						72 08497																	
1. NAME OF DECEASED (Type or Print)												2. DATE AND HOUR OF DEATH											
Pedro De Clarke												8/26/72 8:30 P.M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD												4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY											
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224												Maryland Baltimore C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1001 J. Street 21222											
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-07		9. AGE (In years last birthday) 64		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer						10B. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country) Canada											
12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME Monroe						14. MOTHER'S MAIDEN NAME Lizzie											
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) [if yes, give war or dates of service] Yes W.W.II						16. SOCIAL SECURITY NO. 212-22-0018		17. INFORMANT BCN Records: 4940 Eastern Ave. ADDRESS Baltimore, Md. 2.224															
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  Cardio-Respiratory Arrest  Lympho Sarcoma  1 month											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).																							
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)															
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?															
22. I certify that (I) (this hospital) attended the deceased from 8/19/72 to 8/26/72 and that (I) (we) lost saw the deceased alive on 8/26/72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																							
23A. SIGNATURE Michele Codini M.D.												23B. DATE SIGNED 8/26/72											
23C. PHYSICIAN'S NAME (Type) Michele Codini												23D. ADDRESS BCN 4940 Eastern Ave. Baltimore, Md. 21224											
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 9-2-72				24C. NAME OF CEMETERY or CREMATORY Balti. Cem.				24D. LOCATION (City, town, or county) (State) Balto. Md.											
25A. DATE REC'D BY HEALTH DEPT. SEP 6 1972				25B. NAME OF REGISTRAR [Signature]				25C. FUNERAL DIRECTOR [Signature]				ADDRESS											

MEDICAL CERTIFICATION

VS 150-REV. 1/1/68

Carrie Lexington Street

14th No 2nd Ave

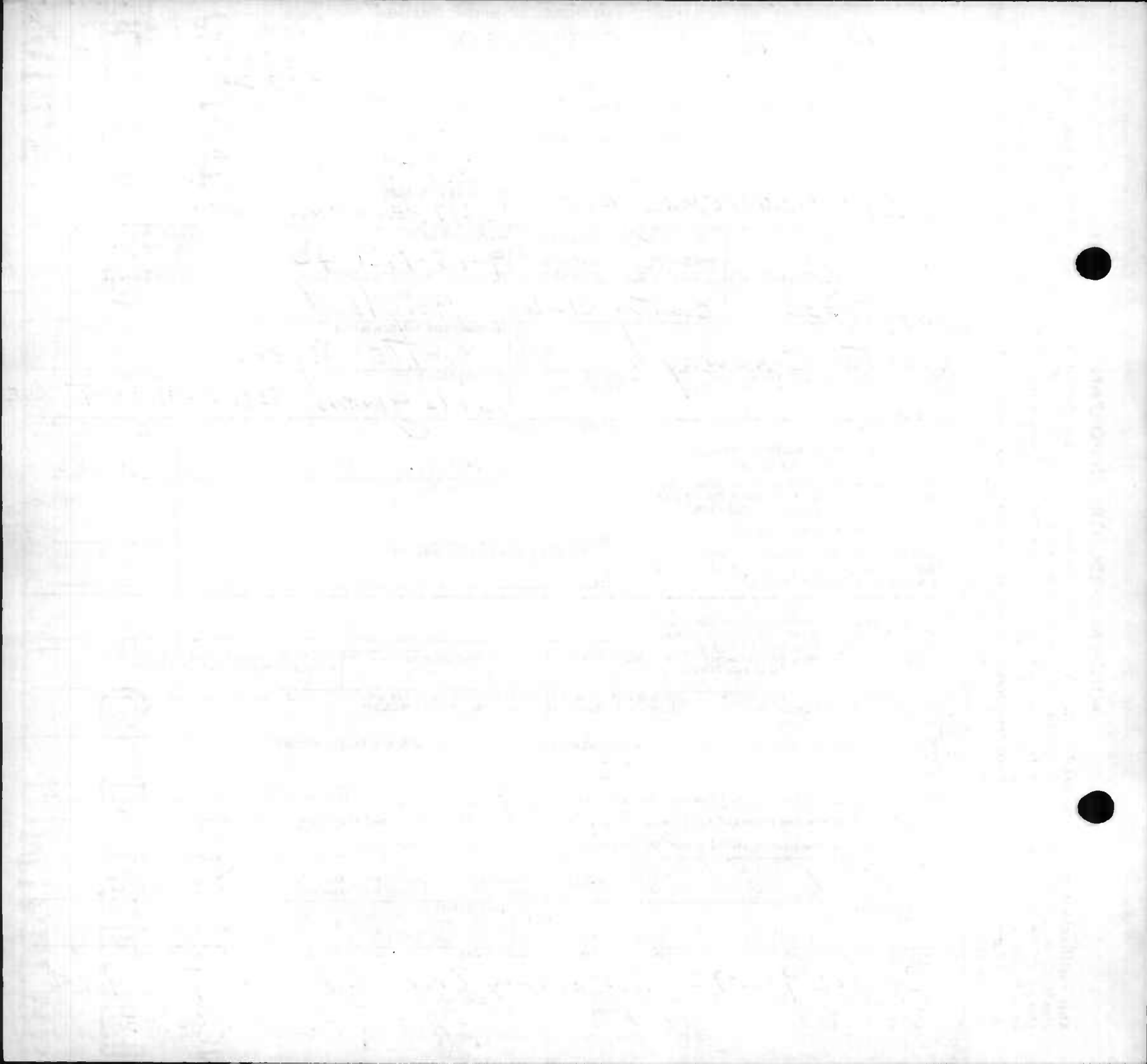
8/15/50 8/15/50 8/15/50

8/15/50  
BCH

Michael (Coxin)  
Michael (Coxin)

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

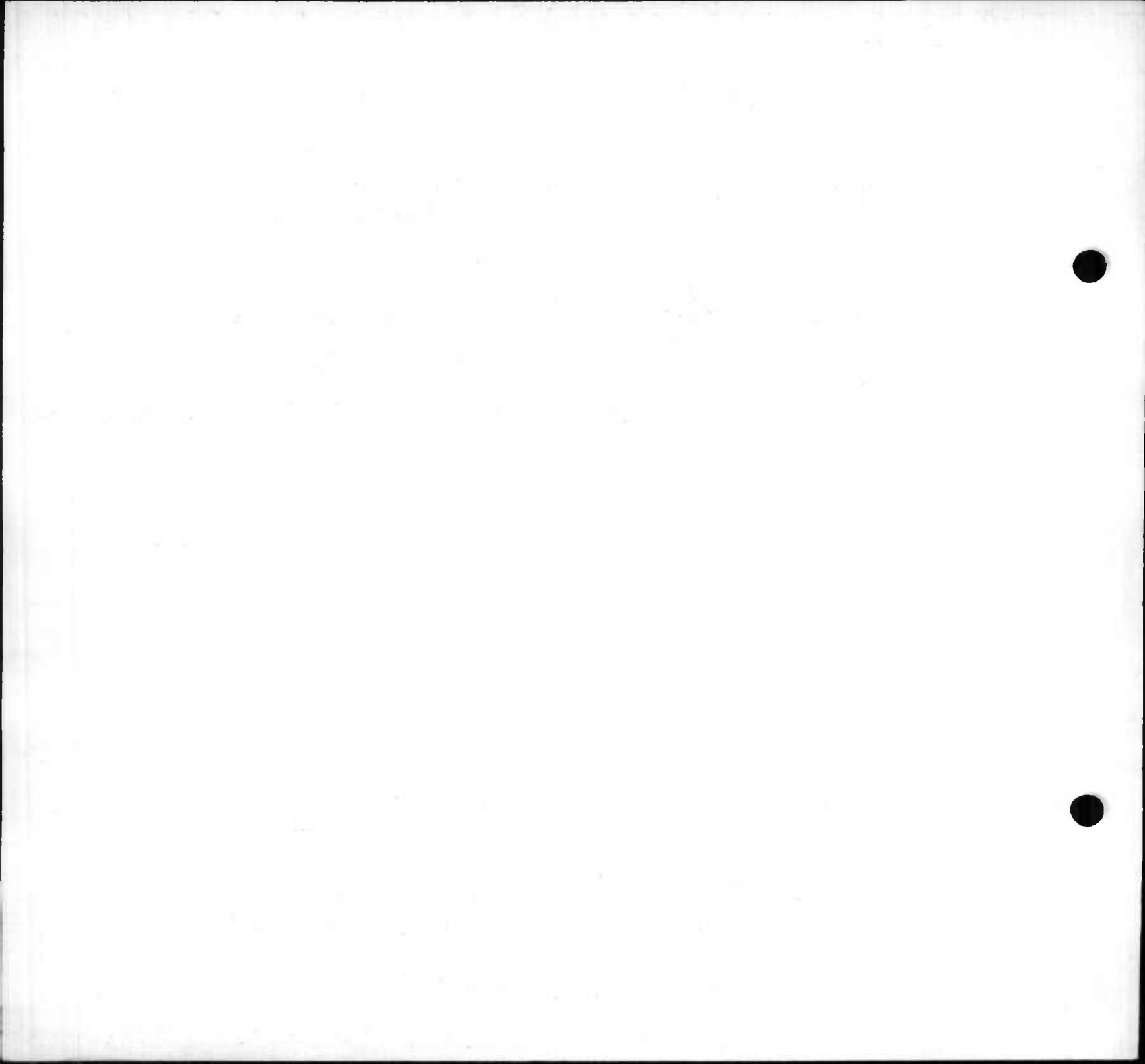
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>S-322 72 08499</b></p> <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 08499</b></p> <p><b>STATE OF MARYLAND-DHMH</b></p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>STOKES, BOB. T.</b></p>		<p>2. DATE AND HOUR OF DEATH <b>8/27/1972 4:30 pm.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>1538</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>2905 Garrison Blvd 16.</b></p>	
<p>5. SEX <b>M</b></p>	<p>6. RACE <b>N</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>12/28/01</b></p> <p>9. AGE (In years last birthday) <b>70</b></p> <p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>North Carolina</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <b>Alford Stokes</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Beel Base</b></p>	
<p>15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <b>213-07-6559A</b></p>	<p>17. INFORMANT <b>Lula Stokes</b> ADDRESS <b>2905 Garrison Blvd.</b></p>
<p>18. <b>3-22 X1</b></p> <p><b>CAUSE OF DEATH</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE <b>URAEMIC COMA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1 day</b></p> <p>(B) <b>Chronic Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF: <b>1 year.</b></p> <p>(C) _____</p>	
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p><b>Hypertension, CHF, CVA</b></p>	
<p>19A. DATE OF OPERATION <b>2</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>Yes</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR?</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that <del>the</del> (this hospital) attended the deceased from <b>8/26/72</b> 19__ to <b>8/27/</b> 19__ that <del>we</del> (we) last saw the deceased alive on <b>8/27/</b> 19__ and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (We) (did) <del>(did not)</del> view the body after death.</p>			
<p>23A. SIGNATURE <b>Antonopoulos</b> <b>MD</b></p>		<p>23B. DATE SIGNED <b>8/27/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>ANTONPOULOS MD</b></p>		<p>23D. ADDRESS <b>Garrett Hospital</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>9/2/72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>(Crown) Maryland National</b></p>		<p>24D. LOCATION (City, town, or county) <b>Laurel</b> (State) <b>MD</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>William H. [unclear]</b></p>	
<p>25C. FUNERAL DIRECTOR <b>William H. [unclear]</b></p>		<p>ADDRESS <b>1727 N. Meade St.</b></p>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and, (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 72 08500 STATE OF MARYLAND-DEATH	
1. NAME OF DECEASED (Type or Print) <b>DAVIS MANNY</b>		2. DATE AND HOUR OF DEATH <b>8/31/72 11: A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1602</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN Hospital Baltimore, Md.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1417 W. MOSHER ST.</b>					
5. SEX <b>M.</b>	6. RACE <b>B.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/6/19</b>	9. AGE (In years last birthday) <b>52</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Longshoreman</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
13. FATHER'S NAME <b>Charles Davis</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Harriett</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-05-1166</b>		17. INFORMANT <b>JOYCE WYATT</b> ADDRESS (Daugh.) <b>503 N. Calhoun St.</b>	
18. <b>160211</b> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cardio respiratory Arrest</b>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Terminal Lung Ca</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-31</b> 19 <b>72</b> to <b>19</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>8-31</b> 19 <b>72</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ruben Manriquez</b>		23B. DATE SIGNED <b>8-31-72</b>		23C. PHYSICIAN'S NAME (Type) <b>RUBEN MANRIQUEZ</b>	
23D. ADDRESS <b>LUTHERAN HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>9/4/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>SEP 6 1972</b>		25B. NAME OF REGISTRAR <b>Dispositional</b>		25C. FUNERAL DIRECTOR <b>William Schiller</b> ADDRESS <b>1727 N. Mount St.</b>	

